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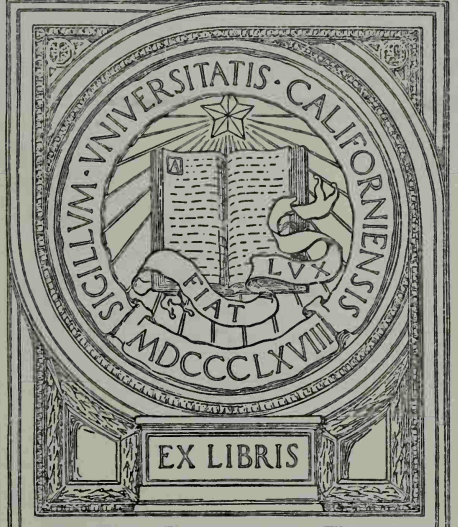

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PUBLIC HEALTH NURSING

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PUBLIC HEALTH NURSING

BY

MARY SEWALL GARDNER, R.N., A.M.

DIRECTOR, PROVIDENCE DISTRICT NURSING ASSOCIATION;
HONORARY PRESIDENT, NATIONAL ORGANIZATION
FOR PUBLIC HEALTH NURSING

SECOND EDITION
COMPLETELY REVISED

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TO
MY BROTHER

CHARLES THORNTON DAVIS

WHOSE COUNSEL AND SYMPATHY
HAVE BEEN TO ME A
CONSTANT SOURCE OF STRENGTH.

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PREFACE TO SECOND EDITION

THE first edition of this book was written during the early years of the war, and was published in 1916. Since its publication the United States has had her own war experience, and following the armistice has passed through six years of great and unprecedented change and adjustment. Any book on public health nursing that fails to take account of the effect of these years on the health movement must fall short of its purpose in representing present-day opinion.

Revision at first seemed a simple matter, a question principally of amplification and correction. In proceeding, however, it became evident that something far more radical was necessary if true expression was to be given to modern trends of thought. Though eight years ago the public health nursing movement had emerged from its pioneer stage of development and was at a point where rapid growth was to be expected, the war, bringing as it did new knowledge of actual health conditions through the draft figures, and a new conception of the importance of national health, greatly accelerated the speed of normal growth and at the same time changed the emphasis on many points. It is this change of emphasis that has made a mere revision of the earlier book impossible, and has necessitated a complete rewriting.

In the preface of the first edition the statement is made that if the then rapid development of public health nursing continued it was probable that much contained in its pages would be of value chiefly as showing the lines of thought leading to later conclusions. This prediction has proved both true and untrue. There has been in these eight years no complete overthrow of once accepted principles and no radical change of method. Rather there has been a development of ideas clearly indicated before 1916, but necessitating a shifting of emphasis of expression on every page. New points of view regarding the educational preparation of the nurse and the value of an educative supervision of her work, the establishment of county health units

with a vast increase in rural nursing, the growing appreciation of the function of the nurse as a teacher, the new importance attached to work with children, the introduction of health education into the schools, the development of the nurse herself in a wider sphere of usefulness; these and other changes of emphasis have produced not only new ways of thinking, but in many instances a new technique, and their effect is to be felt in every part of the work.

In rewriting the book its construction has necessarily been somewhat changed, and eight new chapters have been added. One chapter, that on hospital social service, has, after some hesitation, been omitted, in the belief that this subject should find a place in a book on social work rather than in one on public health nursing.

Certain questions of nomenclature have arisen, chief among them the name to be given to the nurse and to her work as described in these pages. In view of the present tendency toward more generalized methods of administration, and also because the functions of the various nurses are now so closely interwoven, the names "visiting nurse" and "visiting nursing association" have not been used in this book. "Public health nurse" and "public health nursing" have been substituted throughout to describe all types of nurses and organizations.

No one realizes more fully than the author the impossibility of dealing adequately with a subject so large as public health nursing within the limits of a single book, or from the point of view of a single individual. There has seemed, however, a place for a book containing at least an outline of the subject as a whole, in which relationships might be studied and the continuity of events followed. The author has sought counsel and advice from many people whose knowledge in their various fields far exceeds her own. It is impossible to name all of those who have contributed in this way, but grateful acknowledgment is especially due to the following men and women, first to her brother, Hon. Charles T. Davis; to Miss Katherine Tucker, Superintendent of the Philadelphia Visiting Nurse Society; to Miss Ella Phillips Crandall, Associate General Executive of the American Child Health Association; to Miss Gertrude E. Hodgman, Educational Director, National Organization for Public

Health Nursing; to Miss Elmira W. Bears, Secretary for School Nursing of the National Organization for Public Health Nursing (acting as Nursing Division of the American Child Health Association); to Miss Alice Fitzgerald, Former Director, Nursing Department of the League of Red Cross Societies; to Miss Elizabeth G. Fox, Director Public Health Nursing Service of the American Red Cross; to Miss Anne A. Stevens, General Director of the National Organization for Public Health Nursing; to Miss Grace L. Anderson, Director East Harlem Health Demonstration; to Miss Margaret K. Stack, Director Bureau Public Health Nursing, Connecticut State Department of Health; to Miss Mary Elderkin, Chairman, Nursing Committee, National Organization for Public Health Nursing; to Miss Alice Hall, Public Health Nurse, Thomasville, Georgia; to Miss Mary E. Edgecomb, Director, Public Health Nursing Organization, Englewood, New Jersey; to Miss Helen Falvey, Supervisor, Child Welfare Service, Providence District Nursing Association; to Miss Agnes G. Talcott, Superintendent of Nurses, Bureau of Municipal Nursing, Los Angeles; to Mrs. Mary Lippincott, Head Nurse, Venereal Disease Service, Providence District Nursing Association; to Miss Winifred L. Fitzpatrick, Associate Director, Providence District Nursing Association; to Miss Emily Diman; to Miss Eleanor B. Green; to Mrs. Harry P. Cross; to Dr. Arthur H. Ruggles, Superintendent, Butler Hospital, Providence; to Dr. James A. Myers, Assistant Professor, Department of Preventive Medicine and Public Health, University of Minnesota; and particularly to Miss Ada M. Carr, Editor of the *Public Health Nurse;* also to Miss Edith S. Walker, for helpful secretarial assistance.

INTRODUCTION

Those who have been watching the evolution of our old friend the District Nurse through various stages into the Public Health Nurse will probably have noted how closely this growth has been identified with the sanitary and medical advances which have brought forth the modern public health movement. They will therefore have realized that the rapid expansion of health nursing is due not purely to philanthropic impulse, but that it rests upon the solid and stable ground of a well-recognized and permanent social necessity.

They have probably seen how, as the public health movement has grown, it has addressed itself to the more pressing problems of the moment, concentrating its efforts first upon one menacing disease or condition and then upon another, building up machinery to be maintained for their control and ultimate prevention, and then passing on to occupy new fields of activity, and ever sweeping forward with steadily growing impetus. Thus it has devoted itself successively and continuously to the problems of tuberculosis, of the health of school children, of the study and prevention of infant mortality, of the study and prevention of insanity, of the control of venereal, of occupational, and of other diseases; and the interested observer can hardly have failed to note how at the very heart and center of these various efforts has usually been placed the work which nurses, and they alone at present, are prepared to give. In varying capacities nurses have become an integral part of the whole public health movement, so essential and indispensable indeed to the working out of its manifold problems that it appears to be generally understood and accepted that adequate health measures can now neither be established nor maintained without that peculiar kind of cooperation which nurses' training enables them to give. The public health movement had to forge no new instrument for this task; it found an almost perfect one, keen, flexible and potentially mighty, already available in the field. It is not a

far cry from the District Nurse, working and teaching in the homes of the sick and poor and helpless, to the Public Health Nurse who reaches the home by way of the city health department, the public school, the factory or store. It is really a rational and logical step, for medical science has as yet found no better way to speak than through the voice and the personal ministrations of the visiting nurse, no more strategic point of attack than the homes in which she works, no more important factor in the spread of disease than the individuals who are the objects of her constant care and solicitude. With the behavior of these individuals, with their hygienic conduct as it were, public health, it seems, must unceasingly concern itself.

The development and status therefore of public health nursing appear to emerge as a matter of vital public interest, and Miss Gardner has performed an important service in placing at our disposal the first really comprehensive presentation of so timely a subject. From the depths not only of a rich experience preceded by a careful training, but of an unusual understanding of, and respect for, human relationships, she brings forth the mature wisdom which characterizes the book. She is wise in her counsel, wise in her suggestions, wise in her omissions.

It is not only interesting but important for us to know how this work has grown to its present coherence of effort, how it established its field, found its tools and formulated its method; what traditions have been discarded and why, and which there has seemed justification for preserving. The thousands of nurses now at work in this field, the older ones who have blazed their own paths, the younger ones who are just at the starting point, will greatly value these results of acute, accurate and prolonged observation; the careful analysis of typical situations in which small things are neither overlooked nor overestimated, the thoughtful discussions of the many extraordinary relationships which nurses in this work have to sustain and pass on unweakened to their successors, the clear and frequent presentation of the imperative necessity for wide cooperation with others.

Miss Gardner knows her subject from within—every stage of it. For that, the supervisor and the staff nurse will be equally grateful. And she sees it from without as her handling of the important (and infrequently approached) subject, "The Board

of Managers," admirably shows. She reveals herself as a woman of quite exceptional administrative insight. Seen through her eyes complex situations become clarified, difficulties dissolve, things settle into their places and the work moves easily to accomplishment along well-directed lines, the shaping of practical work to the fulfilling of a vision,

> "With great things charged he shall not hold
> Aloof till great occasion rise,
> But serve, full harnessed, as of old
> The days that are the destinies."

But marked as have been the recent advances in this work, and devoted as are its workers, we know that we are as yet but touching the fringe of our great public health problem. In no field in the world is the need at present greater and nowhere is there offered a wider variety of opportunity to render services which are both greatly needed and humanly interesting and satisfying. Not only to those who have already set their hands to this urgent task, and prepared themselves to really help the world by arduous training for its service, but to the very large group of women of liberal education and good upbringing who are anxious to serve but not yet willing to prepare themselves to do so, should Miss Gardner's book appeal. A contribution indeed to the literature of nursing and of service has this valuable public servant of the city of Providence made.

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PART I

THE DEVELOPMENT OF PUBLIC HEALTH NURSING

PUBLIC HEALTH NURSING

Chapter 1

HISTORY OF THE PUBLIC HEALTH NURSING MOVEMENT

On the foundation of a long tradition of self-sacrifice is being built the present structure of public health nursing, the latest development of modern nursing work.

Most movements are developments, not creations, but few have their roots so directly planted in a past filled with inspiration. In that past, skill, as we understand it now, was often lacking because the requisite knowledge to produce the skill did not exist, but a spirit of service was the motive power, and unless that spirit remains, the modern movement, with all its knowledge and all its skill, will have lost more than it will have gained.

Nursing, like so many other things the history of which may be studied from century to century, has had its ups and downs, its bright periods of inspired effort, and its black periods of temporary degradation. Because we have so lately emerged from such a black period, we do not always look beyond to what has gone before.

It is not to the Sairey Gamps and Mrs. Harrises that the ancestry of the modern nurse is to be traced. Sairey was but an unhappy incident in the history of nursing, and the ancestors of the modern nurse are the noble Abbesses and early Christian women who were trying to do for their day and generation what the nurse of today is trying to do for hers.

Visiting nursing, the care of the sick in their homes by those who make such work their business, has undoubtedly existed in almost all ages. When we read of the care given the sick in the centuries before Christ in such enlightened countries as India, Egypt, Greece, and in Rome, we cannot believe that this care was strictly confined to the hospitals. Visiting the sick is not only

spoken of in the New Testament as one of the forms of charity, but long before the Christian era the Rabbis declared it to be incumbent on every Jew "to visit the sick, in order to show them sympathy, to cheer and aid and relieve them in their suffering,"[1] and since the founding of the primitive Church, such work has been a recognized part of its activity.

Deaconesses, Widows, Nuns, and Sisters all consecrated their lives to nursing work, and even from the first few centuries authentic accounts of the work of individual women have come down to us. Perhaps the first visiting nurse whom we know by name was Phebe, who, St. Paul said, "hath been a succorer of many and of myself also."

With the rise of Monasticism came more concerted action for the care of the sick. Those who have visited the Benedictine Monastery founded by St. Benedict in the sixth century, perched on its hill at Monte Casino, cannot but be impressed with the many ways in which the modern settlement idea resembles this community life, with its numberless activities for the good of the people, among which nursing the sick was one of the most important.

For centuries the monasteries and convents stood for all that was then best in nursing, and we of a later generation, who have lived to see the rise of a great secular profession, should not forget that it would have fared ill indeed with nursing if it had not been for the monks and nuns of the middle ages. Without the protection of the strong arm of the Church, individual effort would probably have perished in those stormy times, even if such effort could have found expression in other ways or received its inspiration from other sources.

From the Crusades sprang the military nursing orders; and prominent among them was the order of St. John of Jerusalem, the same order which eight centuries later (in 1874) we find instituting an investigation of district nursing in England.

During the latter part of the eleventh century new nursing orders sprang up outside the Church, though later in most instances these secular orders either voluntarily or involuntarily bowed to the demands of the Church and placed themselves strictly under her control.

[1] Nutting and Dock, "History of Nursing."

Nursing was an important branch of the work of the Beguines, an order which at the beginning of the fourth century is said to have numbered two hundred thousand women working in Belgium, France, Germany and Switzerland, an order which made a most determined effort to maintain its freedom, and independence of ecclesiastical control.[2]

The Sisterhood of the Common Life was essentially an order of visiting nursing, while the more important order of the Santo Spirito seems to have nursed its sick in hospitals.

All through the middle ages these nursing orders existed, many of them tertiary orders, some of them for men, some for women, some for both men and women, and in them the high born and rich and those of lowly birth alike gave their services to the care of the sick. One woman of wealth and position, Mme. de Chantel of Dijon, grandmother of Mme. de Sévigné, at first joined no order, but gave her life to visiting nursing; she also took into her own home single patients who needed her constant care. After her husband's death, with the help of St. Francis de Sâle, she founded the Visiting Nursing Order of the Visitation of Mary. The rule was most simple, involving no vows of poverty, and its members were not cloistered but were "to visit the sick daily, bathe, dress and care for them, taking home their linen to be washed." Unfortunately the decree passed by the Council of Trent in 1545, that every community of women should be enclosed, was a death-blow to visiting nursing work as done by the religious orders. After four short years of activity, the opposition of the Church to this unenclosed community became too strong, and the rule of the order was made over and the visiting nurse work given up.

In all the past, however, there is perhaps no more prominent figure in the history of public health nursing than that of St. Vincent de Paul, who, in the middle of the seventeenth century, with the help of Mlle. Le Gras, founded the world-famous order of the Sisters of Charity. A friend of Mme. de Chantel, he had seen the failure of her scheme of visiting nursing, and he was determined that the sisters should not become religious in the monastic sense—"Nuns," he said, "must needs have a cloister, but the Sister

[2] Nutting and Dock, "History of Nursing."

of Charity must go everywhere—no other monastery than the house of the sick, no other chapel than the parish church." He knew in his wisdom that the work of a visiting nurse was incompatible with solemn vows, enclosures, hours of religious exercises and complete subordination to the clergy,[3] and he knew, too, many other things about visiting nursing. He recognized the necessity of instruction for the Sisters, and gave most excellent advice as to their relation to the physicians; while his knowledge of what we now call social work was so far ahead of his time that he may be said to have really founded the first charity organization on principles not so very unlike those accepted at the present time. His sane wise outlook and the example of his simple life of consecrated self-sacrifice, together with his remarkable power of organization, produced results too well known to require comment. Every public health nurse would do well to know by heart his beautiful description of the Sisters' calling, for it is equally applicable to our modern nurse.

"Their convent must be the houses of the sick; their cell the chamber of suffering; their chapel the parish church; their cloister the streets of the city, or the wards of hospitals; in the place of the rule which binds nuns to the one enclosure there must be the general vow of obedience; the grating through which they speak must be the fear of God; the veil which shuts out the world must be holy modesty."

We sadly need these bright spots, for in the latter part of the seventeenth century nursing entered upon the darkest period of its history. Though Sisters of Charity and Nuns were still in nominal charge of the sick in hospitals, they gave less and less personal care to the patients who were left for such care to the tender mercies of women totally unfit to bestow it.

As we read of the early history of nursing, of the work of St. Elizabeth of Hungary, of St. Catherine of Siena, of the secular orders of the Beguines and the Santo Spirito, and of the later religious orders, both Roman Catholic and Protestant, it seems almost incredible that nursing should have sunk to the level at which we find it in the middle of the nineteenth century, when modern secular nursing was brought to life by Florence

[3] Nutting and Dock, "History of Nursing."

Nightingale, who in turn received her impetus from the Fliedner's Training School for Deaconesses at Kaiserswert.

Even during this dark period good and devoted women were giving their lives to the relief of suffering, but it was only individual effort, and as a rule in every country the great body of the sick poor were being cared for by overworked, ignorant, and unprincipled women, while the sick rich fared but little better.

No dignity was attached to the office of nurse, and in many places no effort was made to obtain women of good character, as the duties were considered too disagreeable to attract the respectable. Even where nursing was nominally in the hands of Nuns and Sisters, little of the actual care of the sick was given by them personally.

This deplorable state of things was not wholly unrecognized, and there are in existence various reports published by doctors and others setting forth the situation. In one or two instances it was even arranged that some instruction should be given the hospital attendants, but no effort was made to secure the services of a higher type of woman, or to make living conditions or hours of work more reasonable.

Though nearly fifteen centuries earlier Roman ladies of patrician birth had devoted themselves to the care of the sick, and though their example has been followed at intervals throughout the history of nursing by those of wealth and social position, Florence Nightingale's assertion that nursing was a work for gentlewomen fell like a bomb upon the people of England.

Outside the protected life of the cloister this seemed impossible. The wonder to us now is that work requiring the best that any woman has to give, should have been allowed to remain so long in the hands of those totally incapable of doing it. We can hardly conceive giving our sick to the care of drunkards and profligates, but it is only by realizing that this was the fate of the majority of sick people that we can comprehend what has been done for the world by the early pioneers of nursing reform, whose names and deeds should never be forgotten by those who follow comfortably in paths hewn out by them with such infinite effort.

Florence Nightingale's contribution is known to every one,

though, owing to her modesty and method of working through others, the remarkable work that she did from her sick bed during the long years of her invalidism has perhaps not always been recognized. The dramatic character of her work in the Crimea is so picturesque as to interest the whole world; but the thoughtful nurse would do well to study her later labors, for as prophetess and health teacher, she has no equal. In paying our tribute to Florence Nightingale, however, we must not forget to accord to Pastor Fliedner and to his two wives, Friedericke and Caroline, the honor that is so justly their due. The seed that later grew and developed into modern secular nursing was planted at Kaiserswert and it was there that Miss Nightingale went to study nursing methods. The deaconesses nursed the sick in hospitals, in private homes, and also did parish or district nursing, the training provided for them being systematic, though simple. The astonishing growth of the work of these Protestant deaconesses all over the world proved its need at the time, though later modern nursing conditions have somewhat changed the position of deaconesses as nurses.

Florence Nightingale did not, as many suppose, found the first school for nursing in England. Two others were established before the Nightingale School.[4] Nor was she alone in her advanced views as to the better training of nurses. Sir Edward Cook in his life of Miss Nightingale says that the reason Florence Nightingale was the founder of modern nursing was because "she made public opinion perceive, and act upon the perception, that nursing was an art and must be raised to the status of a trained profession and that the means by which she achieved this great work were three, by her Example, her Precept and her Practice."

We have touched upon the general nursing situation because it is necessary to realize what already existed in the middle of the nineteenth century before we can comprehend the Herculean task which was undertaken by Mr. William Rathbone of Liverpool when in the year 1859 he founded, with Florence Nightingale's help, the first District Nursing Association in the modern sense of the word.

He cannot, perhaps, be called the first pioneer, for in 1840 Mrs. Fry had made an effort to bring skilled care to the poor

[4] E. T. Cook, "Life of Florence Nightingale."

in their own homes by the establishment of the Nursing Sisters of Devonshire Square in London,[5] and in 1848 there was founded the Society of St. John's House, whose object was to raise the standard of nursing and to provide nurses for hospitals, for private cases and for the care of the sick poor in their homes.[6] Other Anglican Sisterhoods also included visiting nursing among their activities, though the Sisters undertaking it were usually without any adequate training for nursing work.[7] The Bible Women and Nurses' Mission founded by Mrs. Ranyard in 1857 added its quota to the general effort toward the improvement of the physical condition of the poor, but nevertheless it is to Mr. Rathbone that we owe the first definitely formulated District Nursing Association, and in that sense he may be called the father of the present movement.

Owing to illness in his own family Mr. Rathbone had seen for himself the comfort brought to the sick by trained service. He therefore asked the nurse who had been in his own house to undertake as an experiment the care of the poor in their homes for three months. The nurse consented, but at the end of one month pleaded for release from the engagement, saying that she could not endure the misery with which she was brought in contact. After persuasion, however, she agreed to continue for the remaining two months, and so excellent was her report and so great her success in even this short time, that she begged to be permitted to go on, and Mr. Rathbone determined to establish a permanent system of district nursing work for Liverpool.

Miss Hughes in her address made at the Jubilee Congress of District Nursing in Liverpool in 1909 quotes from the writings of a physician showing the views held only fifty years earlier as to the possibilities of the home care of the poor.

"It's evident," writes this pessimistic gentleman, "that the essential conditions of rational and successful sick nursing, such as good air, light, warm bedding, good food, etc., are altogether wanting in the homes of the poor. Of what use are the gratuitous

[5] E. T. Cook, "Life of Florence Nightingale."

[6] Amy Hughes, "History of District Nursing in England and Other Countries," Report of Jubilee Congress of District Nursing.

[7] Nutting and Dock, "History of Nursing."

supply and regular giving of medicines, if every necessary is wanting for ordinary healthy living? It is not that the nurse shrinks from the privations and injurious influences existing in the cottages and hovels, but it is the impossibility of being useful under such circumstances that renders home nursing unattainable for the poor. One can comfort them, and give them food and medicine in their cottages, but to nurse and heal them there with any prospect of success cannot be done."[8]

If this hopeless attitude represented general public opinion, which undoubtedly it did, those who have tried to push through some wholly new idea will appreciate the courageousness of spirit which it must have taken to launch the first district nursing association. Nor was the state of public opinion the only difficulty with which Mr. Rathbone had to contend. There were no nurses in Liverpool to do the work. One cannot imagine intrusting it to the women who were already in the nursing field, women without training, with no standards of efficiency, and in many instances without even a good moral character, to commend them.

Mr. Rathbone applied to Miss Nightingale and to Miss Jones at the Kings' College Hospital, but alas, they had no nurses to send him. Nothing daunted, this courageous Quaker erected a home for nurses on the grounds of the Liverpool Royal Infirmary, and made an arrangement by which systematic training should be given to nurses in order that they might supply the Infirmary and also give care to both poor and rich in their own homes. The care of the rich (private nursing) was only to be done, however, after the needs of the Infirmary and of the poor had been met.

That the right nurses were eventually secured, and the organization well planned, is shown by the fact that within four years eighteen nurses were at work in Liverpool, thus effectually refuting the theories of those who agreed with the doctor whose writings have been quoted, and setting an example which has been followed all over the world.

It is significant even at this early date that the Liverpool nurses were looked upon as not mere attendants on the sick,

[8] Amy Hughes, "History of District Nursing in England and Other Countries," Report of Jubilee Congress.

but as social reformers, and it is also interesting that three other modern principles were recognized. The nurses must be trained nurses. They should not be almoners or dispensers of material relief. They should not interfere with the religious views of their patients. That history but repeats itself, and that the early Liverpool nurses had the same sinful propensity as have their American sisters to avoid the letter of the law in regard to the rule forbidding them to be almoners, is shown by a paragraph in Mr. Rathbone's little book, "The History and Progress of District Nursing." He comments upon the advantages of the District Homes later established, where the nurses worked under more careful supervision, and says, "The establishment of the District Homes proved an economy, as the expense of maintaining the Homes was more than balanced by the reduction in relief."

One feature of the Liverpool work, dear to the heart of its founder, has not, however, proved successful when transplanted to America; that is the placing of a lay woman or group of women in charge of each district, who visit with the nurse and to whom the nurse is responsible for her work in the district.

Others of the large provincial cities of England soon followed the example of Liverpool, and in 1868 the East London Nursing Association was started, but it is evident that the early principles were not always adhered to, for in 1874 we find an investigation of the system of district nursing on foot, inaugurated by the ancient order of St. John of Jerusalem, of which we have already spoken. This investigation brought to light the fact that the whole system of district nursing then existing in England was "amateur, slovenly and haphazard, and that the connection with the physician was very lax."[9]

A result of this investigation was the foundation of the Metropolitan and National Nursing Association in 1875, with its great departure from previous methods in the employment only of nurses drawn from the ranks of educated women, so-called gentlewomen. This departure was apparently so revolutionary that even Florence Nightingale doubted its probable success, saying, "I don't believe you will find it answer, but try it, try it

[9] Mrs. Dacre Craven, paper on District Nursing, read at Congress of Charities and Corrections, Chicago, 1893.

for a year."[10] That it was tried, and that it did answer, reflects great credit on Mrs. Dacre Craven (Miss Florence Lees), for the standard thus set helped the whole movement wonderfully. Her own words are quoted as to her reasons for making the experiment, because the emphasis laid on the responsibilities of the district nurse can only be sharpened by later developments. "There were several reasons for this decision (to employ only educated women) and these were chiefly that in nursing the poor in their own homes, nurses were placed in positions of greater responsibility in carrying out doctors' orders than in hospitals; that women of education would be more capable of exercising such responsibility; that the vocation would attract women anxious for independent employment, and a corps of nurses recruited altogether from among educated women would have a greater influence over the patients, and by their higher social position would tend to raise the whole body of professional nurses in the consideration of the public."[11]

From this time the movement spread in England until in 1887 an event occurred which, as Miss Hughes so aptly expresses it, "raised it all from the sphere of individual effort to the position of a great national institution." The determination on the part of Her Majesty Queen Victoria to devote seventy thousand pounds of the Woman's Jubilee Offering, an offering made personally to the Queen, to the furtherance of district nursing, marks an era in Public Health work. The annual income from this sum was inadequate by itself to accomplish the end in view, but a connection was made with the ancient charity of St. Katherine's Hospital, a charity founded by Queen Matilda in 1148, from which funds were forthcoming. Later through the devotion of a large sum from the amount raised at Her Majesty's Diamond Jubilee, and also by private subscriptions and a commemoration offering, the demands of the Institute were met.

The Queen Victoria's Jubilee Institute for Nurses had a dual object, the preparation of nurses for work among the sick poor in their own homes, and the extension of branches throughout the British Empire.

The majority of the then already existing associations and

[10] Amy Hughes, paper read at International Congress of Nurses, 1901.
[11] Miss Hughes, report of the International Congress of Nurses, 1901.

organizations for district nursing agreed to affiliate. The central nurses' home of the new Institute was established at Bloomsbury Square at the central home of the Metropolitan and National Association, and the Institute became a great force throughout the United Kingdom, apparently fitting its environment perfectly.

A Queen's nurse was in every instance a graduate of a hospital giving a three years' course, and in addition she received a six months' postgraduate training in one of the homes of the Institute. She was at all times under the supervision of the Institute and received from it both support and protection. In addition to the regular nurses of its staff the Queen's Institute, through affiliation with county associations, sanctioned under certain conditions the employment of partially trained nurses who were known as village nurses. The qualifications of the village nurse as set forth by the Institute were as follows: "Village nurses employed by County Associations must be certified midwives under the Midwives' Act (1902) and shall have (a) if possible, twelve months, but in no case less than nine months, district and midwifery training; or (b) approved hospital training to be followed by not less than three months approved district training."[12] The conditions under which they were to work if affiliated with the Institute were also distinctly enumerated. "The Queen's Institute will only sanction the employment of village nurses (a) in a rural district where it is impossible to support a Queen's nurse and the population of the district does not as a rule exceed three thousand; or (b) in a district in which a Queen's nurse is already employed and where special conditions make it desirable that a village nurse also be employed under her direction."[13]

It was not long before a third type of nurse came into existence in England—the so-called cottage nurse—who was as a rule of the same class in life as her patients, and who, if needed, stayed in the homes, helping with the housework as well as caring for the sick. These nurses were not necessarily, like the village nurses, certified midwives, and their training, which was

[12] Queen Victoria's Jubilee Institute for Nurses, A–1.
[13] Queen Victoria's Jubilee Institute for Nurses, A–1.

in most instances of short duration, was obtained outside the walls of a hospital.

The war threw a new light upon health conditions in many countries. In England, as in America, the tabulated results of medical examination for military service disclosed a far greater degree of physical disability than had been suspected, and the desirability was recognized of vigorous action for the improvement of health throughout the country. After a study of the various governmental departments having to do with health a general amalgamation was recommended under a minister of health. The new ministry at once interested itself in a broad health program which included definite work with mothers and children. For this the cooperation of the Queen's nurses was sought, but in addition health visitors were utilized. The English health visitor has not her exact prototype in America, though several efforts have been made to introduce a similar type of health worker in this country. The Queen's Institute had long recognized the fact that hospital training alone does not equip a woman for even the simpler duties of a district or public health nurse. The following point of view expressed by the chief medical officer of the Board of Education is therefore a not unnatural development of this already accepted opinion:

"Health visiting is social, educational, and preventive work. It is not in the narrow sense remedial or curative. The training given in a general hospital is not designed to equip a woman to become a health visitor. It was, therefore, considered that, in view of their primary function, health visitors need not be required to possess full nursing qualifications, though there are clearly many advantages in a sound understanding of nursing, and the habit of duty, discipline, and devotion acquired in the course of hospital training is in itself a valuable acquisition quite apart from the technical knowledge gained. Yet, by general consent, the hospital trained nurse requires further instruction in the prevention of disease to give her the outlook and attitude of mind which the health visitor should have."[14]

The health visitor is not a new thing. As early as 1908 an Act was passed sanctioning the employment in London of suitable women as health visitors, their duties, qualifications, etc.,

[14] Annual Report of the Chief Medical Officer of the Board of Education, 1919.

to be regulated by the Local Board.[15] Though the training of health visitors is still avowedly in an experimental stage, the short periods of training first offered are now officially discountenanced, and two-year standardized courses are prescribed.[16] Several such courses are offered in different parts of the country by universities, schools of science, etc., these connections securing for them the prestige of academic sanction. The introduction of the health visitor is an interesting experiment and one that is being attentively watched in America. It is perhaps in too early a stage of development to warrant criticism but to most American health workers a division of responsibility for sick nursing and health teaching seems undesirable.

Before turning to the United States, let us emphasize the fact that the history of public health nursing is continuous. What we are, we have become through those that have gone before, and the great leaders are of no country, but of the world. Florence Nightingale's wonderful precept and example belong no less to America than to England, and to the well-organized work of our mother country we owe a debt which, in our busy lives, we do not often enough stop to acknowledge.

[15] Requirements were as follows:

(a) A medical degree; or

(b) The full training of a nurse; or

(c) A certificate of the Central Midwives Board, or some training in nursing and a Health Visitor's Certificate of a society approved by the Board; or

(d) The previous discharge of duties of a similar character in the service of a Local Authority.

Annual Report of the Chief Medical Officer, Ministry of Health, 1919–1920, quoted from "Evolution of Public Health Nursing," Annie M. Brainard.

[16] Shortened one-year courses are offered in connection with the two-year courses for fully trained nurses and for women whose previous experience fits them to profit by a one-year course.

Chapter 2

history (continued)

In all countries public health nursing is dependent upon the status of nursing as a whole, for unless properly trained nurses are available, progress in any branch of nursing is impossible.

In America, as in England, the sick have been cared for by Nuns and Sisters, both in and out of hospitals, since the earliest settlement days. One cannot read of the hardships so heroically endured by the Sisters in their efforts to nurse the Indians in Canada in the first half of the seventeenth century, without thrills of admiration; and at an even earlier date Spanish Nuns were at work in the hospitals of Mexico.

The Pilgrim fathers and mothers, however, came to the new world for other reasons than those which brought their French and Spanish neighbors. They came to make for themselves homes, and their religion took little heed of the Indian or the state of his soul. Among the early Canadian settlers, on the other hand, were Jesuit priests, who came for the sole purpose of converting the savages and saw in the nursing skill of the Sisters an important means to that end. Indeed, Montreal came into existence as a mission consisting of three communities, one of priests to manage the affairs of the colony, one of nuns to teach the faith to children, and one of Sisters to nurse the sick; and all this was arranged in obedience to what was believed to be a direct revelation of God, before there was any colony to manage, any children to teach or any sick to nurse.

The newly established communities in the English colonies were not long without their sick, and as the little villages grew, hospital provision was made. The first hospitals, Blockly in Philadelphia and Bellevue in New York, were started as what we would now call poor-houses, and dreadful indeed was their nursing history. No tales of the neglect and cruelty of English almshouse nursing of the same period can exceed those of these

two hospitals. Lurid pictures come down to us of drunken attendants fighting like furies over the beds of their patients, or lying in sodden unconsciousness beside the bodies of the dead.[1] Fortunately for the sick, the past of all the early hospitals is by no means so black. The Philadelphia Hospital, the first in the United States in the sense of being an institution designed solely for the care of the sick, has a totally different record, while the Massachusetts General Hospital in Boston seems always to have been able to secure as nurses women of good character and dignified demeanor.

Training schools for nurses were a later development. It is not easy to assign to any hospital the honor of being the first to establish a training school. The New York Hospital undoubtedly made the first effort to teach its nurse attendants in 1798, and the Nurses' Society working with the Philadelphia Dispensary, in 1839 gave outside instruction and training in obstetrical nursing. In 1861 the Philadelphia Hospital also opened a training school, though the first applicant did not present herself until two years later, in 1863.

It was the Civil War which was destined to give the greatest impetus to nursing in the United States. Its effect was almost as far reaching as had been that of the Crimean War on English nursing. True, no great personality like that of Florence Nightingale emerged, but many women of real ability came to the fore, doing admirable work, both as members of the Sanitary Commission and as nurses in the field. Their energies once aroused could not in the nature of things die away into inactivity, and after the war women everywhere began to interest themselves in the better care of the sick in times of peace. The result was the opening of training schools for nurses in various parts of the country.

The New England Hospital for Women and Children established its training school in 1872, the first of the modern type, and Miss Linda Richards, its earliest graduate, is called the first American trained nurse. Controversy has always run rife in regard to a definition of the term "training school." To those students of American nursing history who feel that the term

[1] The training schools of these two hospitals now stand among the best in the country.

can only rightly be applied to schools founded on what is commonly known as the "Nightingale system," the training school established at Bellevue Hospital in charge of a nurse superintendent in 1873 (eight months after the New England school), has a just claim to priority. Similar schools were established in the same year at the New Haven Hospital and at the Massachusetts General Hospital.

Long before the trained nurse made her appearance, however, some efforts had been made to care for the sick at home.

Aside from the Sisterhoods, the first organized work of this kind that we know of was undertaken by the Ladies Benevolent Society of Charleston, South Carolina, in 1813. This Society had a visiting committee composed of sixteen ladies, who themselves visited the sick, a certain portion of the city being allotted to each visitor. When necessary, nurses were engaged who worked under the visitors. Again it is interesting to see in this very early beginning that the danger of becoming almsgivers, rather than nurses for the sick, was recognized. The visitors "could give no money except to eight chronic cases and no more." This method of caring for the sick of Charleston worked well for fifty-two years, and had it not been that the Civil War scattered its members, undoubtedly the activity of this society, which celebrated its centennial in 1913, would have been unbroken. Indeed, the actual ministrations to the sick never did wholly cease, although no regular meetings were held for twenty years. In this country, where tradition plays all too small a part, we are glad to record the reconstruction of this old society, and the fact that in 1902 a trained nurse was engaged. The work is now being carried on according to the usual modern methods.

Undoubtedly, if we could but learn of them, there were groups of women elsewhere, who cared for the sick in some similar way; but unfortunately, no such record remains.

In 1849 Pastor Fliedner brought over four German deaconesses who had been trained at Kaiserswert, and established them in Pittsburgh in a hospital and deaconesses' home which was in readiness for them. It was not until 1877, however, that an American organization first systematically sent trained nurses into the homes of the "sick poor," and it is to the Woman's

Branch of the New York City Mission that this honor belongs.

A little later the New York Ethical Society placed nurses in dispensaries in New York, afterwards sending a nurse to Chicago to begin similar work there in 1883.

In 1885 Dr. Alfred Worcester, of Waltham, Massachusetts, established a training school in which some of the ideas of Pastor Fliedner were carried out.

In 1886 district nursing was organized in Boston. In the same year an Association was established in Philadelphia. In 1889, Chicago followed, and in 1893 the Henry Street Settlement was founded, where, in spite of its many and varied settlement activities, visiting nursing has always been the chief work.

A further chronological list of the visiting nurse associations is unnecessary. It will be more profitable to compare the beginning of the public health nursing movement in this country with that in England.[2]

In 1890, thirteen years after the first trained nurse was sent out by the New York Mission, there were in the United States twenty-one organizations engaged in visiting nursing. These organizations had no connection with one another, and no common standard of efficiency, either in practical work or in the educational requirements for the nurses. This is not surprising, for there was at this time no national association of nurses, although the association idea in other branches of work was well recognized; nor had nurses begun to take part in any of the national congresses or conventions, then common enough in lines closely touching their own. The first training school Alumnae Association, that of Bellevue Hospital, was not formed until 1889 and the earlier efforts toward union seemed at first only to widen the distance which already separated graduates of different schools.

In the United States, therefore, each city and town started its visiting nurse work in its own way, and continued in its own way, with the divergence of method to be expected under such circumstances. In England, on the other hand, the newly organized Queen's Institute set definite standards for everything: methods of work, requirements of training, records, uniforms even to the cut of a sleeve, and for many years this centraliza-

[2] A chronological list of dates will be found in the Appendix.

tion continued. As the progress made in each country was very genuine and real, and the results from the point of view both of alleviation and prevention differed but little, it would seem that each seed was planted in the soil best fitted for its individual growth. In America, with the formation in 1893 of the first national nursing association (The Society of Superintendents of Training Schools), the value of interchange of ideas was recognized, and national organizations, annual conventions, personal acquaintance and frequent correspondence made plain the value of mutual help. Nevertheless each public health nursing organization in the United States, whether publicly or privately controlled, has remained an individual unit, self-governing in every way, and only optionally joining, if eligible, the membership of a national organization for purposes of mutual assistance and strength.

In England, on the formation of the Queen's Institute, the great majority of the existing associations affiliated with it, accepting from the Institute supervision of their nurses, and conforming to certain fundamental rules which governed the administration of their work.

Growth in the United States was very slow at first. We have an interesting glimpse of the situation in 1901 from the report of the Third International Congress of Nurses held in Buffalo in that year. Of the fifty-eight organizations listed as doing such work, only in twenty-two instances were the nurses working under associations founded for the sole purpose of visiting the sick. There seems to have been a strong connection with charitable organizations, twelve of the groups of nurses being employed by distinctly relief-giving agencies. The hospitals were responsible for nine more, sending out pupil nurses for the work. The remaining fifteen nurses, or groups of nurses, are found working under the auspices of settlements, churches, guilds, and, in one instance, a municipality. There were in the employ of these fifty-eight organizations about one hundred and thirty nurses.

From 1894 the establishment of visiting nurse associations progressed somewhat more rapidly. In 1898 Los Angeles led the way, by being the first city to inaugurate municipal nursing. Not long after this appeared the earliest tendencies towards

specialization. In many places special nurses had been set apart for obstetrical work, and as early as 1902 the New York Department of Health engaged nurses to care for cases of diphtheria, scarlet fever and measles. These were employed for separate diseases, purely for technical reasons, and in order to avoid the carrying of infection, and not because of any particular hope of increased development of the specialty. The years 1902 and 1903, however, witnessed the rise of two special branches of public health nursing, which were destined to be the forerunners of many so-called specialties.

In 1902, after a month of experimental work provided by the Henry Street Settlement, the Municipality of New York followed the lead of England in establishing school nursing, and in 1903 the first nurse was set apart for tuberculosis work. These, and other special branches of nursing, will be dealt with individually in later chapters. Here it is purposed merely to trace the sequence of events, to note tendencies, and if possible to gain an idea of the possibilities of future development. The whole question of specialization or, as many think, over-specialization, is an interesting one. There are now in the United States nurses specializing in school nursing, tuberculosis, venereal disease, mental hygiene, medical-social service, industrial nursing and prenatal and child welfare work; and although recently the tide of specialization seems to have turned, each year still sees new lines of work separated from the main body of public health nursing through the employment of special nurses.

One is tempted in explanation to make the trite remark that this is an age of specialization. But why is it so? and, have we done well in following the general trend and making of it an age of specialization for public health nursing? This latter question is so important, and so many and diverse opinions are held on the subject, that space will be given to a full discussion of it in a later chapter. On one side lies the danger of weakness arising from division, non-centralization and lack of coordinated effort; on the other, the equal danger of loss of strength and progress that are to be gained only from concentration. To sail between the Scylla and Charybdis of these difficulties needs thoughtful and able seamen, on the alert to read the signs that mark the real channel.

The slow, somewhat apathetic, growth of public health nursing continued until 1905. From this time development became more rapid. New associations sprang up, many more nurses were employed, and the strength of the whole movement increased numerically and otherwise.

As the demands upon the nurse multiplied, the question of her training became increasingly important. In the early days little beyond the physical care of the patient was thought of, and for this a hospital training seemed sufficient preparation. It was the nurse herself who, feeling her own limitations, proved the necessity for something more. The nursing care of her patients led to efforts on her part to better their condition in other ways; and as she found herself unable to compass this alone, the broad field of cooperation was opened up. The moment the nurse who had behind her only a hospital training, supplemented, perhaps, by a few years of private nursing or institutional work, found herself confronted with social problems, she was at a loss; and often, she only gained her fullest efficiency by weeks, months, and sometimes years, of blundering experience. As the complexities of public health nursing grew, the truth that had been recognized from the first by the Queen's Institute in England forced itself upon those interested in the subject in America; namely, that a hospital training was not sufficient, and that a public health nurse needed special training to fit her for her work. In England from the first no nurse was accepted on the staff of the Queen's Institute until she had added to her hospital training six months' of postgraduate work in one of the homes of the Institute. As this had been an accepted necessity for Queen's nurses since 1888, it seems strange that in America we were so slow to recognize a like need.

The older associations were for years besieged by those newly organized to send them nurses possessed of experience in visiting nursing. In spite of a very generous desire on their part to meet this need, and although valuable women were parted with, often at great sacrifice, the demand everywhere greatly exceeded the supply. In consequence town after town was forced to make a beginning with nurses who had never done a day's public health work, and the results were as varied as the personalities of the nurses themselves. Fortunately, public health nursing has

always appealed to a fine type of woman. Had it been otherwise, the results would have been quite different. At best, however, time was lost while well-intentioned nurses gained their experience through mistakes made because of ignorance of conditions never before encountered.

Undergraduate public health training was early attempted, sometimes through affiliation with a visiting nurse association whereby pupil nurses were sent out from their hospitals for short periods of training in the districts of the association, sometimes directly by the hospital itself which assumed responsibility for supervision. For the most part, such efforts were too little organized from an educational point of view to prove successful, and both pupils and work alike suffered from the arrangement. Later developments of undergraduate training are securing excellent educational opportunities to the student; and the teaching possibilities of the public health field both for graduate and undergraduate work are well recognized. At present, however, public health nurses for the most part receive their special training by means of the postgraduate courses offered by universities in affiliation with public health nursing organizations.

The first postgraduate course was offered by the Instructive District Nursing Association of Boston in 1906. Since then such courses have been established in various parts of the country, Columbia University leading the way in a recognition of the responsibility of the University for the higher education of nurses.

In 1909 a new aspect of public health nursing presented itself when the Metropolitan Life Insurance Company undertook to offer home nursing to its millions of industrial policyholders in the United States and Canada. Arrangements were made, where possible, with existing visiting nurse associations to furnish this nursing, payment being based upon the exact cost of the visits made. A new field was in this way opened, the development of which has been of importance. In addition to the actual nursing work accomplished, a number of health studies have been made by the Company, and tabulated data based on the statistics kept by the nurses are proving of great value. The tendency of the Company towards an increase in the use of the nurse's time

for instructive work in the home is an interesting comment on the value of such work in the actual conservation of life.

From time to time isolated efforts have been made to provide a nursing service to meet the needs of the great body of people of moderate means requiring continuous nursing care and household assistance. In 1909 a modest effort of this sort was begun in Brattleboro, Vermont, under the name of Household Nursing, three types of workers being provided: graduate nurses, supervised non-graduate nurses who performed household duties in addition to caring for the sick, and women for housework in times of illness. Other efforts have been made elsewhere in the United States and also in Canada to develop an "attendant service" of untrained women to work continuously in the homes under trained supervision, but as yet the practical difficulties of administration have proved so great that there has been no noteworthy development of the original idea.

Everything which affects nursing in general has naturally had an effect on the public health nursing movement. In 1901 the first effort was made in the State of New York to secure nursing legislation. The bills presented to the different state legislatures have varied greatly according to local conditions and local opposition, but the effort was everywhere the same, namely, to set, and to maintain, a required standard for the education of nurses. Where opposition occurred it was usually from those interested, for one reason or another, in lowering the standard. As state after state has fallen into line, the day has at last come when people everywhere have the same protection in selecting a nurse that they have long had in selecting a physician, dentist, pharmacist or plumber.

It is interesting to compare the position of the public health nurse in 1912—a quarter of a century after the first visiting nurse association had been established in Boston—with her sisters of the very early years of the century. The nurse of 1912 had already become one of a considerable army, numbering over 3,000, while ten years earlier only one hundred and thirty-six visiting nurses could, by diligent search, be discovered in the country. This mere numerical increase is significant, for no factor, either for good or evil, increases so rapidly without a cause.

We find the nurse of 1912 supported in these numbers by both private and public funds without great difficulty, because her need was generally accepted by the community. We find other agencies counting not only on her help in individual cases, but upon the knowledge which she has gained from her unique position. We see that she has had her effect on state and city legislation, and has influenced public opinion to effect non-legislative reform. We find her valued as a preventive agent and health instructor by municipalities and state bodies, and the usefulness of her statistics acknowledged by research workers. We find her acting as probation officer, tenement house and sanitary inspector, county bailiff, domestic educator and hospital social service worker. She is found in the juvenile courts and public playgrounds, in the department stores and big hotels, in the schools and factories, in the houses of small wage-earners and in the swarming tenements of the very poor. We find her in the big cities, the small towns, the rural districts and the lonely mountain regions. We find her dealing with tuberculosis, babies, mental cases, industrial workers, expectant mothers, midwifery and housing conditions.

All these things she had done, but until 1912 there was one thing she had not done. She had never associated herself with other American public health nurses in any country-wide organization to set standards for her special work, and to strengthen it by mutual association. Such standards as existed were on the whole good, but they were set merely by the example of the stronger and better organizations. Leaders in nursing affairs had long been troubled by the situation, feeling that in the unprecedentedly rapid growth of the work lay danger unless some method of standardization could be devised.

In building, each stone rests upon some other stone. To the American Nurses' Association (formed in 1896 as the Associated Alumnae) and to the League of Nursing Education (formed three years earlier as the Society of Superintendents of Training Schools) the National Organization for Public Health Nursing owes its existence. In 1911 a joint committee from these two societies was appointed to consider the question of standardization for public health work. Letters were sent to all registered organizations employing public health nurses (1,092) asking that

they send to the annual nurses' convention delegates empowered to vote on the question of forming a national organization. The response was encouraging; many sent delegates, and most of those who could not, wrote of the need they personally felt for such an organization.

The annual meetings of the American Nurses' Association and the League for Nursing Education were held in Chicago in the month of June, 1912, and there came into existence a third national body, the National Organization for Public Health Nursing, the purpose of which was expressed in its constitution as follows:

"The object of this Organization shall be to stimulate responsibility for the health of the community by the establishment and the extension of public health nursing; to facilitate efficient cooperation between nurses, physicians, boards of trustees, and other persons interested in public health measures; to develop standards and technique in public health nursing service; to establish a central bureau for information, reference and assistance in matters pertaining to such service; and to publish periodicals or issue bulletins from time to time in the accomplishment of the general purpose of this Organization."[3]

Like the League for Nursing Education, this organization bears a close relationship to the American Nurses' Association, but it differs from the other two national nursing organizations in that it provides for lay membership, thus bringing in the great body of lay men and women engaged as directors and officers of local associations in guiding the policy of public health nurs-

[3] Changed in 1922 to read as follows:

"The object of this Organization shall be:

"1. To stimulate responsibility for the health of the community by furthering the establishment and extension of Public Health Nursing, and the education of nurses in public health.

"2. To develop standards and technique in Public Health Nursing.

"3. To facilitate efficient cooperation between nurses and health officials, physicians, boards of trustees and other agencies and persons interested in public health.

"4. To establish and maintain a central bureau for information, reference and assistance in matters pertaining to Public Health Nursing.

"5. To publish periodicals and to issue bulletins from time to time to aid in the accomplishment of the general purpose of this Organization."

ing. The value of such an organization was immediately felt. Standardization was simplified and the advantage of a central representative body generally appreciated. When public health nursing staggered under the overwhelming demands of the war upon the nursing resources of the country, the National Organization for Public Health Nursing was able to make clear the necessity of this branch of the public service, with the result that public health nursing was early recognized as one of the important factors in national conservation.

In the same year which saw the formation of the National Organization for Public Health Nursing another event of importance occurred. In 1912 the American Red Cross inaugurated a system of rural nursing that in its beginnings was not unlike that of the Victorian Order in Canada. The name of the new department of the Red Cross was at first "The Rural Nursing Service," but was later changed to "The Town and Country Nursing Service," in order that small towns as well as the strictly rural sections of the country might consistently be included within its scope. The aim of the service was to furnish to rural districts and small towns nurses specially trained for such work, and to maintain over them a general supervision without, however, assuming local financial responsibility. With the vast war expansion of the Red Cross this service was reorganized under the name of the Bureau of Public Health Nursing, and the work decentralized in accordance with the general Division plan of organization. At present (1924) over a thousand Red Cross public health nurses are at work, scattered through every state in the Union.

Pioneers in any new venture rarely have time to write about their efforts. For this reason, and because nurses do not as a rule turn to literature as a means of self-expression, there has been until recently singularly little nursing literature, particularly literature pertaining to public health nursing.

Since its publication in 1900 the *American Journal of Nursing* has been of inestimable value, and from the beginning has given a place in its columns to public health nursing in its various forms. In 1905 the first magazine relating to visiting nursing was published in Chicago, *The Visiting Nurse Quarterly*. After two years of precarious existence this magazine perished for

lack of support. In 1909 a more successful effort was made in Cleveland when an unpretentious little magazine, also entitled *The Visiting Nurse Quarterly,* was brought out by the Cleveland Visiting Nurse Association. On the day on which the National Organization for Public Health Nursing came into existence the Cleveland Association presented it with the Quarterly as a christening present. Under the familiar title of *The Public Health Nurse* this magazine is having a useful and successful career. There is a constantly increasing pamphlet literature on subjects affecting the work of the public health nurse and books on general and special aspects of nursing are making their appearance. No greater contribution is likely, however, to be made than the exhaustive "History of Nursing" written by Adelaide Nutting and L. L. Dock, published in 1907.

At the present moment (1924) the public health nursing movement in America is passing through a most interesting period of development. The early pioneer stage drew to a close in 1914, the value of the work having been more or less generally accepted. Not only were well-supported private organizations to be found all over the country, but a growing consciousness of state, county and municipal responsibility was widely evidenced. With the war, and particularly with America's entry into the war, involving as it did the enlistment of thousands of nurses for foreign military service, a wholesale abandonment of home health work seemed at first inevitable. It was perhaps natural that in the enthusiasm for military preparation emphasis should be placed mainly on first-line activity, but fortunately for the cause of public health nursing the reverse swing of the pendulum of public opinion came in time to prevent disruption. The truism, that no effective first line can exist without other carefully guarded lines behind it, was seen to be no less true of health than of military matters. The result of this perception was a greater appreciation of the importance of home health work, and incidentally of the nurse's part in all health programs. The nurse rose gallantly to her part, accepting new responsibilities, entering new fields, doing in many instances not only her own work but that of her sister nurse absent in France, and herself growing with the necessity for growth.

Two specific war services were rendered by the National Organization for Public Health Nursing. A Washington office was opened and the executive secretary of the organization moved to Washington to act as secretary for two nursing committees under the General Medical Board of the Council of National Defence and for a third, under the Committee on Labor. The associate secretary was also released for duty as General Supervisor of Public Health Nursing of the United States Public Health Service, and a notable piece of work was done by her in the organization of public health nursing services in twenty-two extra-cantonment zones. Of this work Surgeon General Blue said: "For the first time in its history, the United States Public Health Service during the recent war organized a division of public health nursing. The work which these nurses performed was of inestimable value. It is not too much to say that without their aid our success in keeping down sickness in the extra-cantonment zones, and in making the venereal disease rate in our army lower than in any other army in modern times, could never have been achieved."

Since 1914 the United States has suffered from a serious shortage of public health nurses. This was to be expected during the war, but on the signing of the armistice it was generally felt that with less stimulation there would be less demand, and also that with the demobilization of nurses from military service enough women would be available to meet the needs of the country. This did not prove to be the case. Apparently the greatly increased demand for nurses was not due to that artificial type of stimulation which later produces reaction, but rather to a growing perception of the possibilities of the work itself.

We are yet too near the war to gauge in full measure its effect on any of the movements of the day. In those countries, however, in which before the war she had already found a place, the public health nurse emerged from it as a distinctly more important figure in national health work; while in other countries an effort to secure her services is more or less strongly evidenced. In England, it is true, the "Health Visitor" has come into existence, a woman trained for the preventive and educational side of public health work alone. It remains to be seen

whether or not her introduction in the health field tends to sharpen unduly the line of demarcation between prevention and alleviation, and whether or not with the withdrawal of the stimulation of preventive effort the more intelligent and constructive type of women will be deflected from the nursing field, thus weakening the whole cause.

He who ventures to predict, ventures always upon perilous ground, and prediction is less than ever possible at a time when the world is passing through a period of unprecedented readjustment. Various tendencies seem to show themselves, but whether they foretell the real trend of future development, or whether they are mere ephemeral evidences of temporary phases of thought and action, it is impossible as yet to say.

At the present moment no tendency is more marked than that which points to a more and more complete assumption of responsibility for health work by states, counties and municipalities. Does this mean that eventually all public health nursing will be recognized as an essential public responsibility as is the school system, the police force and the fire department?

The private organization, which was never so strong as today both as regards prestige and money-getting power, is also developing considerable earning capacity through the employment of its nurses by those who can pay for their services, or for whom the service is paid. On the other hand, the cost per visit seems everywhere to be increasing, and this in spite of distinctly improved business methods. Better work is undoubtedly done, but is there danger that the cost of the work will become prohibitive? What relation do these two tendencies bear to the tendency toward state and municipal control noted in the preceding paragraph?

The public health nurse has long been valued as a worker. In America certain recent occurrences would seem to denote a growing appreciation of her value as a thinker and a counselor. Such an occurrence was the inclusion of the National Organization for Public Health Nursing as a constituent member of the National Health Council, a small body composed of representatives of the more important national associations having to do with health.

If public health nursing can attract to itself a sufficient num-

ber of well-educated and intelligent women, it seems probable that the public health nurse will find a natural place in all councils which deal with problems of health. It is for the nurse herself to prepare for this by study, observation and the habit of wise, temperate and open-minded thinking.

Chapter 3

FOREIGN DEVELOPMENTS

Lest the impression be gained that England and the United States have a monopoly of public health nursing, at least a cursory glance should be taken at the work in other countries.

In the far past, as we have tried to show, many of the European countries played well their parts in the nursing movements of the day, monks and nuns dedicating their lives to the Church and caring for the sick as an outward expression of their religious faith. Such nursing still continues to a certain extent in many foreign hospitals, but few such nurses care for the sick in their own homes. Where standards of nursing education are low, organized public health nursing hardly exists. Thus in the countries of southern Europe until recently there has been little or no systematic care of the sick in their own homes, and no home health teaching; while in the north such development has gone hand in hand with advancing standards of nursing education.

The war has had a tremendous effect in accelerating and changing the slow processes of natural development. Thousands of English and American nurses entered Europe, many of them, particularly after the armistice, for the sole purpose of public health nursing. Both at home and abroad the postwar program of the American Red Cross was a program of public health, narrowed in Europe to a child health program, but everywhere involving the employment of public health nurses in large numbers. Quite naturally, since public health work as understood by Americans takes for granted the use of that indispensable tool, the public health nurse, every effort has been made to introduce her into European work. This has implied the establishment of training schools for nurses in such countries as were without them, and the training by means of short courses of small groups of native women to replace the Ameri-

can nurses when the latter were withdrawn and before the new schools could graduate their first classes.

At the moment of writing, therefore, we have throughout Europe, more especially in the war-devastated regions of eastern Europe, a hint of a wholly new attitude toward the nurse and the field of public health nursing. While much of the stimulation for this nursing work has come from outside sources, and is therefore somewhat artificial, and while these infant projects are perhaps too new to warrant any form of prophecy, nevertheless it seems safe to say that the nurse is undoubtedly making for herself a place in Europe which she is likely to keep.

In addition to these pieces of home work in individual countries, an interesting experiment in international effort has been made by the League of Red Cross Societies, the results of which cannot fail to affect public health nursing in various parts of the world. In 1920 the League of Red Cross Societies offered its first course for public health nurses at King's College for Women, London, England, the students to be, as far as possible, women who represented the highest standards of nursing education afforded by their respective countries. A number of scholarships made the course possible for those who would otherwise have been debarred in these hard post-war years. The course was repeated in 1921, 1922 and 1923 at Bedford College for Women, London, and during the past three years the following surprisingly long list of countries has been represented:—America, Austria, Belgium, Bulgaria, Canada, Czecho-Slovakia, Denmark, Esthonia, Finland, France, Great Britain, Greece, Hungary, Iceland, Italy, Japan, Latvia, Mexico, New Zealand, Peru, Poland, Portugal, Roumania, Russia, Serbia, Siam, Sweden, Switzerland and Venezuela. The students, with the exception of one student from Russia, are all reported as having returned to occupy public health positions of more or less importance in their several countries.

It must not be gathered from the foregoing that all European public health nursing is the outcome of foreign stimulation. In some of the countries nursing has developed along wholly native lines, and the public health work of the nurses owes no more to foreign example than does any other modern enterprise of the day.

In Sweden visiting nursing has been in existence since 1888, and is now organized under central control.[1] Swedish nurses are engaged in visiting nursing, child welfare, tuberculosis, industrial nursing and school inspection.

In Norway all the various branches of public health nursing are carried on, a national tuberculosis league being particularly active in the furtherance of tuberculosis nursing.

In Denmark work is organized under a central association supported by the government.

In Finland until 1912 district nursing was mostly done by deaconesses, but in that year the Finnish Nursing Association sent out its first district nurse. Good work has also been done in tuberculosis.

In Holland associations for district nursing have existed in the principal cities for many years.

In Germany the older forms of the work were originally in the hands of the Church, but the newer lines such as tuberculosis, baby welfare, etc., have been undertaken by municipalities. Since the war the German Red Cross has opened nurses training schools to teach tuberculosis care and prevention, child welfare nursing, midwifery and general public health nursing.

Austria before the war had developed child welfare nursing along excellent lines. In spite of the heavy handicap of her present crippled condition this work is being continued.

In France the first modern visiting nursing was started in Bordeaux as an extension of the dispensary service of the Protestant Hospital. It was there also, through the influence of Dr. Anna Hamilton, Director of the hospital, that school nursing came into existence under graduate nurses. Since the war a number of excellent pieces of public health nursing work have been carried on in France, but French nursing will never come into its own until the French people awaken to the necessity of an adequate number of good training schools.

Belgium is well under way with an association, *l'Association des Infirmières Visiteuses,* which furnishes nurses for the various branches of public health work. Tuberculosis and visit-

[1] For much of the following information the author is indebted to the League of Red Cross Societies.

ing nursing are also being carried on by the Cavell nurses, and public health courses have been organized.

In Italy a good beginning has been made, though in Italy, as in so many other European countries, the lack of an adequate number of graduate nurses holds back the work. Short courses are being given in a number of the principal cities, a nursing examination being required before admission to the course. These Italian public health nurses are known by the descriptive name of *Assistenti Sanitari.*

Switzerland has established short courses in public health nursing, and nurses are engaged in child welfare, tuberculosis, and general visiting nursing, also in school and industrial inspection.

Eastern Europe, largely through foreign stimulation, is also awaking to the value of the public health nurse. In the Baltic Provinces, Poland, Czecho-Slovakia, Serbia, Hungary, Roumania, Bulgaria, Greece, Montenegro, and Albania, American public health nurses, with a few of their English sisters, have done excellent work since shortly after the armistice, demonstrating public health nursing through their own activities and endeavoring to train native women to replace them. The modes of approach, and the results, have differed in different countries. In some, strong governmental support has been secured, as in Czecho-Slovakia. In others the usual Anglo-Saxon form of community committee is relied on to carry out the work, as in Poland. In others again some organization quite peculiar to the country has been utilized. This is the case in Serbia, where there is an active peasants' cooperative society onto which it seemed possible to graft the new health ideals. In Athens, Greece, child health work has become very popular and enthusiastic volunteer assistance has been secured, as well as the lively interest of the Queen.

Most encouraging of all, good general training schools are being established in a number of the countries, and in these schools it is planned that public health nursing shall have a place in the curriculum.

Some years ago a Japanese nurse came to America to be trained, first at the Women's Hospital in New York and after-

wards at the Henry Street Settlement, in order that she might go back to organize visiting nursing in Japan. Other Japanese women have followed her example and visiting nursing has been started by several of the Chapters of the Japanese Red Cross. The students in the Red Cross training schools are receiving general instruction in public health subjects.

Chinese nurses are also in America, training in the hospitals and taking the postgraduate public health nursing courses with a view to the establishment of public health nursing in their own country.

In South America, Brazil and the Argentine Republic and Peru are making a start. In the Argentine there is a central public health nursing organization with headquarters at Buenos Aires, and all the usual branches are included in the program. In Brazil the Government is planning the program, and an American nurse is at work in Rio de Janeiro organizing the native work under municipal control.

In Cuba each locality has its own independent government organization doing child welfare work, tuberculosis, industrial nursing and home visiting. The Cuban nurses have been carefully trained under American guidance, and show promise as public health nurses.

In the Philippines, where at least old prejudice and errors of nursing education had not to be overcome, there being no nursing traditions whatever, it is interesting to see that development is due not to tradition and not alone to outside help, but primarily to a realization by government officials of the needs of their country. Health centers have been established by the Philippine Health Service and the Public Welfare Commission, at Manila and in the provinces, to which graduate nurses have been assigned. These stations include child welfare centers, maternity clinics, day nurseries, special dispensaries for tropical diseases, and from them a certain amount of home visiting is done. The first course for training health nurses was established in 1923 under university auspices.

In other countries wherever English prestige exists there are as a matter of course English nurses possessed of English nursing standards, and trying through training schools to impress these standards as far as is feasible on native pupil nurses.

In Australia district nursing is no new thing, and an effort has been made to extend it beyond the limits of the cities and towns into the bush. This "bush nursing" corresponds to what is known with us as rural nursing. In New Zealand the same thing is being done under the name of "back block nursing," a name quite misleading to the ordinary city nurse. In New Zealand child welfare work has been so successful as to become world-famed, and one of its foundation stones is the home visitation of mothers.

In South Africa public health nursing is being done under English auspices, a monthly report of the work from Johannesburg reading amazingly like a similar report from any American city.

Canada has the excellent system of the Victorian Order, which is analogous to the Queen Victoria's Jubilee Institute in England, and which was started in 1897 to commemorate Queen Victoria's Jubilee. This Order, with its high standards, stretches across the entire continent from Halifax to Vancouver. In the far northwest tiny cottage hospitals have been established to meet the needs of that sparsely settled land. In Canada the usual forms of public health nursing:—tuberculosis, industrial, school, infant welfare and hospital social service work, are undertaken as in the United States, both by municipalities and by private organizations. In Toronto and Halifax interesting experiments of complete municipal control, and a new form of divided responsibility are being worked out with interesting results.

The English or American reader must not gain from this brief outline of work in foreign lands a mental picture of universally well-established public health nursing. In most foreign countries it is still in the earliest stages, stages which England and America passed some twenty or thirty years ago. Foreign public health nurses are few in number, and are for the most part as yet imperfectly trained women. A trained nurse of any sort is too unfamiliar to be readily understood, and the average community has by no means grasped the opportunities for service that she offers. In many places the excellent plans of organization exist principally on paper, but these plans are better than those with which our own work was usually started. If hospital

training schools can be established with proper provision for public health training, and if a steady sustained public interest can be aroused and maintained, there is no reason why public health nursing should not in time become universal.

Dr. C.-E. A. Winslow says, "Public health in most countries has passed from a stage in which sanitation of the environment was its chief preoccupation, to one in which control of infection by epidemiological, bacteriological and serological methods is dominant: and from this second stage it tends to proceed to a third, in which the emphasis is laid on the hygienic education of the individual."[2] Undoubtedly it is because of this change of emphasis on the part of the medical profession and the general public that the work of the public health nurse has acquired its present importance. The advantages to any locality of a permanent organization of trained women which in times of disaster or epidemic can be readily augmented to deal with emergency situations, has been proved many times. It is not, however, to her efforts in these dramatic, and fortunately rare, moments of public danger that the public health nurse owes her place of importance in the health work of the day, but rather to the fact that day in and day out she solves the problem of the care of the unhospitalized sick, and because she has been found an indispensable part of the health program of those communities which, as Dr. Winslow expresses it, are laying special stress on the hygienic education of the individual.

In closing this slight outline of the Public Health Nursing Movement let us look for a moment at three public health nurses at work in three widely separated parts of the globe. Their heroism in doing their duty under difficulties cannot fail to be an inspiration, but an even greater inspiration lies in the thought that hardly a public health nurse exists in any land who would not as readily respond to a like call, for the spirit of service is the same in all.

First, let us have a glimpse at a Canadian nurse of the Victorian Order, sent to the Klondike in the early days. "Leaving Dawson, after the first fall of snow, she tramped twelve miles

[2] Winslow, C.-E. A. (member of the American Red Cross Mission to Russia), "Public Health Administration in Russia," Washington, Government Printing Office, 1918 (Reprint No. 445, Public Health Report).

over Bonanza Trail to Grand Fork, through slush and mire, accompanied by the Rev. Mr. Dicky. On arriving she was taken to the hotel to assure her a more comfortable rest after her weary tramp. She was shown into a room without any light, save from the hall, and on looking around she discovered a number of men asleep. In dismay, she went to the landlord, and told him she could not sleep there amongst all those men. 'Lor', Miss,' he said, 'you will find a row of women on the other side on the floor (the men had beds) and you will find a place all ready for you, and if you will only wrap a blanket around you and leave your skirts on the stair rail, I will see that your clothes are dry by morning.' She found in the hospital, if the miserable building could be so called, ten patients, all bad cases, and simply no conveniences. Pole frames over which a blanket was thrown for beds, not enough blankets to keep the patients warm, no sheets, no towels or cloth of any kind save a few flour sacks, a slop pail, a hand basin and soap box for furniture. The basin and pail were borrowed from the butcher, perhaps the box too. Bread, bacon and rice, and very little sugar constituted the daily bill of fare. No fresh meat, no butter or milk, the patients' only food being principally boiled rice and gravy; yet they recovered. The nurse's sleeping room was the corner of a corner called by courtesy the doctor's office, and here, behind a little curtain, in an atmosphere thick with tobacco smoke, the tired nurse, rolled up in her sleeping bag, lay on the floor."[3]

The back block nursing in New Zealand presents the following picture. "One of our district nurses was summoned in the night by a lighthouse-keeper in the Sounds. His wife was in labor. At once the nurse set out, and after a wild rough ride and a scramble she arrived three hours late, to find her patient almost pulseless from hemorrhage, and the baby cold and almost lifeless. She set to work, and her efforts were rewarded, and both mother and baby saved. Here it was an impossibility to get the doctor. He was thirty-five miles away. Immediately after the arrival of the nurse the tide came up, and the lighthouse was completely isolated."[4]

Our last illustration is of district nursing as carried on in

[3] Report of Jubilee Congress of District Nursing.
[4] L. L. Dock, "History of Nursing," Vol. IV.

South Africa during the siege of Kimberly. "Our brave district nurses went about their work through all the bombardment as if nothing were going on. I cannot tell how miserable I felt seeing them go out in the morning while the awful roar, shriek overhead and crash like the crack of doom, were raging outside. By God's mercy none of them were injured, but their escapes were marvelous. Several of them were covered with dust and debris of the explosions, and all narrowly missed death by the awful hundred-pounders. It was a matter of deep thanksgiving to see each one come in safely from her round, though it was only to start off again in a few hours. It was true war nursing; through the shot and shell of the siege, half starved themselves, ministering in the most hidden way among the wretched starving people of the town, with the greatest patience and simplest courage."[5]

[5] Transactions Third International Congress of Nurses.

Chapter 4

FUNDAMENTAL PRINCIPLES

At the foundation of any type of activity which springs more or less spontaneously into existence there will be found certain principles that are recognized as fundamental, not so much because they have worked well in any particular instance, as because they are everywhere felt to be of vital importance. In addition to these basic principles many and various methods of work have been adopted to fit varying conditions and different periods of time. These may sometimes seem to be quite as important as the fundamental principles that are universally accepted, and it is only by a careful study of the public health nursing movement as a whole that it is possible to distinguish between the two.

England as well as America must be considered in looking for these fundamentals, because a number of them date back to the time when William Rathbone, with the far-seeing assistance of Florence Nightingale, founded the first district nursing association in Liverpool. Though time and a natural development are producing constant change, we may perhaps for the sake of convenience group these fundamental principles under nine headings.

First principle—Mr. Rathbone felt from the beginning the necessity of employing well-trained nurses, even at a time when there were none to be had. As succeeding years have laid an increasingly heavy burden of responsibility upon the nurses, an even greater emphasis has been placed upon this first fundamental principle.

The much quoted bishop who thanked God that there were second-rate souls to be saved by second-rate parsons is perhaps the prototype of the many kind-hearted men and women, who, feeling somewhat the same way about sickness, are inclined to believe that any good woman is capable of mastering the ordi-

nary technique of public health nursing in a comparatively short time, and will prove sufficiently satisfactory for the average position.

In countries where there are but few trained nurses the problem is a difficult one, and possibly it is wise to start the work with women whose training is avowedly inadequate. Where this is necessary, however, the arrangement is usually looked upon as a temporary one, anticipatory of a time when better prepared nurses may be available. In England and America various efforts have been made to organize subsidiary nursing groups to work under the supervision of more highly trained women. In England these efforts seem to have been attended with a certain amount of success, but in America none of the experiments so far tried have been sufficiently successful to warrant any widespread emulation.

As early as 1908 Lady Helen Ferguson, in a paper read at the Jubilee Congress in Liverpool, spoke of "the ignorant managers who are apt to think any pleasant young person in uniform, with some nursing history behind her, capable of understaking duties the complexity of which they are not in a position to realize."[1]

Lady Helen has touched the real difficulty. It is not in reality a financial problem, but a question of comprehension of the duties and responsibilities of a public health nurse, and if those who contemplate the inauguration of public health nursing, in any of its forms, will first consult those of wider experience than themselves, the dangers of unstandardized work will be avoided. At present the tendency is certainly toward a higher, not a lower, standard of education, and there is a constantly increasing demand for women who have added to their hospital training some form of special preparation for the public health field. In addition the necessity of systematized programs of staff education is recognized by all the better organizations.

It may be assumed, therefore, that this fundamental principle, the employment of only well-trained nurses for public health nursing, is now, as it was half a century ago, one of the foundation stones of the work.

A *second* fundamental principle is that which emphasizes

[1] Report of Jubilee Congress in Liverpool.

the teaching function of the nurse. The duties of a public health nurse have recently been reformulated and classified under three heads: First, the care of the sick; second, the prevention of disease; third, the promotion of health. This does not mean that the last two duties are new. The value of health teaching was early recognized, and the first district nurses were expected, in addition to their care of the sick, to teach the principles of health. As the years have gone by, however, greater and greater emphasis has been laid on this aspect of the work until in many branches it has become of first importance. Indeed the time has perhaps already come when the order of the duties quoted above should be changed, and the care of the sick placed last as claiming the smallest part of a nurse's time and effort. That every nurse who enters a home should be prepared to give definite and suitable health instruction is now so generally accepted that the fact needs no reiteration, and the specific education of the public health nurse is very largely concerned in fitting her for this function. The field of teaching is constantly widening to keep pace with the advance of medical, sanitary and social knowledge, and now ranges from the rudiments of cleanliness and decent living, which must be taught to the ignorant foreigner, to the most advanced theories of infant care taught to the intelligent mother of a problem child. Indeed it is principally as a teacher that the public health nurse has justified her existence. The large expense required for her support would hardly be warranted for a program of mere alleviation. To meet adequately the threefold responsibility laid upon her, a nurse, in even the most obscure position, must be a teacher of no mean order. The sick can only be properly cared for by a suitably instructed family; disease can only be prevented if methods of prevention are thoroughly understood; and health can only be promoted by a widespread knowledge of the principles that underlie it. No public health nursing therefore is possible without the inclusion of this important principle.

Third—The observance of professional etiquette was another of the fundamental principles of the early days, and by professional etiquette is meant the relation of the medical and nursing professions to public health work and to each other.

Public health nursing has had in the medical profession one

of its greatest friends, and also not infrequently one of its greatest stumbling-blocks, and this seems to have been the case everywhere.

The finer and more broad-minded physician has always recognized the public health nurse as a co-worker. The more narrow-minded members of the profession have regarded her with suspicion, and feared her interference at every turn. Men whose minds have been steadily fixed on the welfare of the people, have from the first gladly given to the nurse a helping hand, and with a fine loyalty sought to strengthen her position. Men occupied chiefly with their own personal careers, who have feared that the public health nurse might jeopardize either their authority or the amount of their work, have persistently denied her the loyalty they have so rigorously demanded for themselves.

Which influence has been stronger is shown by the growth of the work itself, for without cooperation from the medical profession such development would have been greatly retarded.

As a matter of fact, public health nursing has increased and not decreased the work of physicians everywhere; and it is encouraging to hear from all parts of the country that former opponents are being won over and becoming, first, non-combatants, and then loyal allies. This assuredly would not be the case were it not for the universal observance of the rules of so-called professional etiquette.

In their essence these rules are merely an affirmation of the fact that a nurse should not take upon herself duties and responsibilties rightly belonging to the physician. In detail they mean that she should not diagnose and should not prescribe, and that in her relations with the patients she should use her influence to strengthen the position of the physician in charge of the case. Public health nurses serve a wide field, and in their work they come in contact with all types of doctors. It is inevitable that there should be among them a certain number of inferior men, and that occasionally a patient suffers from the strict observance of the rules of professional etiquette. Nevertheless, on their observance rests the whole relationship of the two professions. All rules need occasional revision, but only chaos can result from haphazard disregard of rules.

It must be remembered that imperfect nurses as well as im-

perfect doctors exist, and both professions should be considered as being represented by the whole group, and not, as sometimes happens, by a fine representative of one as against an indifferent representative of the other. General rules cannot be made to depend upon personality.

The nurse who is struggling with a dying baby in the hands of a physician totally uninterested in babies cannot but be rendered miserable as she thinks of the fine baby specialist round the corner. The problem, however, is not solved by forcibly taking that particular baby out of the hands of that particular doctor, and placing it in the hands of the specialist. It is solved only by the gradual education of public opinion to the point where the importance of baby work is understood.

It is a wise rule that a doctor shall be in attendance on every case cared for by public health nurses,[2] and it is an equally wise rule that the nurse should continue on a case only if it is his pleasure. In case of change of doctor, and every public health nurse is familiar with the dizzy rapidity with which such changes may take place, it is her duty to put herself in immediate communication with the new doctor, and usually it is wise to have a word on the subject with the departing one, lest she become involved in the complexities of the situation.

There are signs abroad that the time is ripe for a revision of old rules of professional etiquette, and this suggestion of revision is coming from more than one member of the medical profession. In many parts of the country the pioneer stage of public health nursing is passed, and in passing has produced a degree of standardization that makes possible many things that were impossible at an earlier period. In effecting this standardization nurses have played their part well, and have won for themselves a place which they did not occupy ten years ago.

Changes of this kind always come slowly because such codes as that governing the relation of the medical and nursing professions are the result of a slow accumulation of experience and tradition. In taking new steps an orderly sequence

[2] This general rule must admit of certain exceptions in rural work, and also for instructive services under municipal or state auspices where responsibility is assumed by the health department.

should prevail, for it has been found that in the long run real freedom has lain, not in a reckless independence of what has sometimes seemed the unnecessarily rigid rules of professional etiquette, but in a disciplined submission to those rules which have, on the whole, been worked out for the greatest good of the greatest number.

Fourth—Another fundamental principle of which, however, we did not hear so much in the very early days of the movement, is cooperation. Everywhere the public health nurse stands as one of the most valuable cooperative agents of the community. This has, perhaps, been a rather unexpected development of her work, but had she failed to respond to this demand and confined her usefulness to the nursing care of her patients, public health nurses would hardly have been counted by thousands, as they are today. Cooperation has not only done much for the patient and his family, and much towards strengthening the hands of other agencies, but it has done more than many nurses realize to relieve public health nursing itself of its most unbearable features. Many an early nurse remembers how constantly the misery she encountered haunted her off-duty hours. This was largely because she was helpless to deal with it herself, and did not know how to get the assistance she needed. In order to be a good cooperator it is first necessary to know and observe a few simple rules. Unless this is done, cooperation is as impossible as would be a game of whist if trumps were changed to suit the convenience of each player. True, a game played in this way might well be astonishingly successful for any one of the four individuals playing it, and in the same way a disregard of the rules of the game of cooperation will sometimes produce single results unattainable in any other way. But in both instances it would probably be found that this independently minded player would hardly be wanted for a second game. The well-meaning nurse who light-heartedly plays her own game, pleading ignorance and good intentions when she gets into trouble, is capable of doing more harm than can be undone by a whole staff of good nurses, and ought not to be engaged in this branch of nursing until she is better informed.

A public health nurse is not expected to do for her patients

work that properly belongs to another agency, even though she may honestly believe that she is capable of doing it better. If one charitable agency is dealing with a family, that family is not to be taken from them and placed in the hands of another, even for the very good reason that organization number one is weak and organization number two is strong.

Any criticism of another agency is of course intolerable, but a nurse should go farther and should try by her helpful cooperation to strengthen the weak worker. What is technically known as "reporting back" is a valuable practice, based on the principle that a case belongs to the agency originally dealing with it, and that this agency, therefore, has a right to all helpful information gathered from other sources. Occasionally a nurse is puzzled as to her duty in this connection because, in her desire to be a good cooperator, she fears to betray confidence reposed in her by her patients. Each situation must be dealt with individually, but if service to the family is her watchword she cannot go far astray; and often by an honest statement of her connection with the assisting society all semblance of betrayal of confidence may be removed. As regards evidence for legal proceedings, if summoned to court as witness the nurse has no choice but to appear and tell the exact truth, as would any other citizen. Often, however, because it is undesirable that she should frequently appear in this way, it may be arranged that she shall be spared giving evidence in open court unless it is absolutely needed for final decision, though her presence may be required through the trial. This is undoubtedly one of the most unpleasant duties imposed on a public health nurse, but she must comfort herself with the thought that in not a few instances the information that she possessed has alone made possible the administration of justice.

The ability to see the other person's point of view is of course the greatest help in cooperation; but inability to do so is no excuse for non-observance of the rules.

Indeed a certain degree of lack of understanding is almost inevitable, because of the very varying angles from which every situation is approached. Each type of worker will usually be found conservative in his own line. The trained social worker sometimes seems to the impatient nurse to be straining at gnats

in a painstaking effort to investigate each case, and an unwillingness to plunge into remedial measures till this is accomplished. The societies which have prosecuting powers are indignantly arraigned because, in their efforts to obtain legal evidence, precious time seems to be lost. The nurse whose soul is tried by these things rarely stops to remember that in her own profession she herself is conservative to the last degree. Is it not probably just as difficult for the lay mind to understand why a nurse should so persistently refuse to prescribe the simple remedy which all the world is administering at home without medical advice, or why, when it is so obviously for the best, she will do nothing about getting a sick child into the hospital merely because the foreign doctor in attendance does not like hospitals?

Occasionally criticism or a plea for greater efficiency becomes necessary, because all the social work of a community is being held back by some agency which fails to do its part. This, however, should never be done by the nurse, but should be a matter for most careful consideration by her board of directors.

One of the key-notes of cooperation is intelligent tolerance.

Part of the value of the young public health nurse lies in the fact that she fully expects to change everything in the world that needs changing. Let her by all means keep this dynamic spirit, but let her realize that she is not going to do it at once or alone. To reach her goal she must be willing to use all the forces of her city, from the timid volunteer with her inexperience to the worn veteran with his somewhat immobile mental attitude. She must also be willing to act without the sure hope of herself seeing the promised land. It must be enough that the promised land of municipal health exists, and that she has been privileged to share in leading the chosen people of her city toward it.

We are at the present moment passing through a period in the development of public health work that gives to the matter of cooperation a peculiar importance. There are many more types of health workers than formerly, and in a number of instances their field of activity not only touches that of the nurse, but overlaps and blends with it. Where, for instance, does the work of the health educator end and that of the school

nurse begin? And how about the social service worker, the nutrition worker, the occupational therapist, the psychiatric social worker? As yet the boundary lines between much of this work and public health nursing is so undefined that the assignment of respective responsibility is extremely difficult. The day will undoubtedly come when more standardized work will make possible a clearer definition of duties and responsibilities of every type of health worker. Meanwhile cooperation, and cooperation alone, can be relied on to prevent overlapping and confusion.

But in placing cooperation among the fundamental principles of public health nursing, more is meant than an individual effort to work well with other individuals or agencies. The last few years have seen many manifestations, both local and national, of a new tendency to federate or amalgamate activities previously quite separately administered. To accomplish this, councils or central committees under various names have been created, and in the work of these committees nurses are taking an active part, rendering in this way important service for the advancement of better forms of community cooperation and coordination.

Fifth—When Mr. Rathbone founded the Liverpool district nursing association in 1859 he made a point of non-interference with the religious views of his patients, and this is an important rule in all present-day organizations. So much emphasis has always been placed upon this point that it is rare indeed to hear of a case of proselytizing by a public health nurse.

All, however, has not been said when the nurse is adjured not to interfere. This is merely negative. From her position in the home she can often give positive help in strengthening already existing church connections. Broadly speaking, the three great forms of faith with which she comes in contact are the Roman Catholic, the Protestant and the Jewish.

Every nurse should be familiar with certain Roman Catholic principles:—that a Catholic baby should not be allowed to die unbaptized, or an older Catholic without the last rites of his church; that a Catholic child must not be placed in a Protestant family, even temporarily, or sent away for a summer outing where he cannot attend mass on Sunday, without the full

consent of his pastor; and to these she should give unfailing attention.

The Protestant patient is often found without church connection. He has perhaps drifted away from his earlier associations, or has recently moved and failed to make himself known at the church which he has been attending, and he will gladly receive the suggestion that the nurse telephone to some minister or clergyman of his special denomination, asking that he call. The last months of many a lonely, hardened life have been quite changed because of this little effort on the nurse's part.

With the Jewish people the question is more complex, because the Jewish customs are more difficult to understand and because they so affect the daily life of the people. A call on a Jewish Rabbi made by the nurse early in her career will sometimes save her much embarrassment in the homes of her Jewish patients, for he will willingly explain how she may avoid trampling upon the religious feelings of the orthodox Jew. One well-meaning nurse discovered that she had transgressed no less than four times in her first half hour in the home of a good old Jewish woman to whom the religious customs of her fathers were far dearer than the life which the nurse was trying to save.

The whole question of the religious views of the patients is not a difficult one if the nurse remembers that as a public health nurse she represents not her own religious faith, but the spirit of helpfulness, which, though it may be fed by personal religious feeling, expresses itself in the effort on her part to strengthen all bonds that make for the better life of the patients.

Sixth—The importance of accurate records, which may now be accounted as one of the fundamental principles of public health work, has not always been emphasized.

In many early American visiting nurse associations, doing otherwise excellent work, a very imperfect system of record keeping existed without apparently disturbing the minds of any one. This may not have been the case in England, but at least the keeping of records was not sufficiently emphasized to be one of the points dwelt upon in early books or magazine articles.

This is explainable by the fact that in the beginning alleviative, rather than preventive, work was considered the function of the public health nurse, and any time spent away from the bedside of her patients was looked upon as of doubtful value. If records were to be kept it had to be "between times," a period which is non-existent with the average nurse; and even had she struggled to fill out a modern history card it is doubtful if any one would have made use of it.

With the growth of cooperation, and the increasing demand for information, it became evident that the public health nurse had unusual opportunity for collecting valuable data. The tendency in every branch of work was toward a greater emphasis on accuracy, and vague statements founded on general impressions carried less and less weight. Supporters of the work demanded figures as to results, investigators of special conditions asked permission to consult records, the nurse herself began to feel the need of a longer look backward than was possible out of her own experience if she was to take an intelligent look forward in planning her campaign.

The business connection of a majority of the visiting nurse associations with one of the large insurance companies also had its effect, for measured against the absolute accuracy of this business concern the comfortable methods of even good amateur record keeping showed in their true light. With the growth of the work and the development of methods of supervision came, too, a need for a type of record hitherto unnecessary, while the insistent demand for more scientific data regarding actual health conditions made every organization realize the importance of a suitable record system. All modern health work is built upon the foundation of definite knowledge. The public health nurse's part in contributing to this knowledge is an important one and few health studies are complete without data compiled by her.

On the whole, the public health nurse responded more slowly to this demand than to any other made upon her, but gradually she realized that not only accurate, but complete records were a vital part of her work, and that by keeping them she was perhaps rendering one of her most valuable services to the cause of public health.

Seventh—The fundamental principle having to do with payment may be divided into two parts: first, that those who can afford to pay for nursing service shall do so according to their means; second, that free service shall be provided for those who cannot afford payment.

The second part of this principle is as old as the first visiting nurse association. The first is a much later development. From the point of view of payment, patients calling upon the public health nurse may be divided into four groups: those who can make no payment; those who can make partial payment; those who can pay cost price, but cannot afford a private nurse; and those who can afford anything, but call upon the public health nurse for convenience.

In the first group are those who can save nothing from their inadequate income against the rainy day of illness. Any attempt to do so would mean such curtailment of the ordinary necessities of life as would hasten that very end. When, therefore, illness reduces or cuts off the meagre income they instantly sink below the self-supporting line, and if nursing is to be provided, it cannot be at their own expense. There are also always a certain number who, because of sickness, age, widowhood or some other handicap, never rise to the level of self-support at all, and these, too, must go without nursing if they are obliged to pay for it.

In the second group are those who can, with care, make a very slight provision for sickness, or whose income in ordinary times permits of expenditure slightly beyond the point of mere necessity, and who in times of illness, by economy at this point, can pay a small sum for nursing care.

In the third group belong those whose incomes are well above the line of dependency,—who always expect to pay reasonable prices for everything that they obtain, and who are able to meet the expenses of illness without undue anxiety. The price, however, of a graduate nurse, resident in the house, is prohibitive, though they are well able to discriminate between her services and those of an untrained woman. To this group also properly belong many whose outward circumstances may seem to imply a mode of life imposed on them by birth and tradition, but who in reality may be exercising a more rigid economy than is neces-

sary to the artisan or clerk. To both these elements the public health nurse comes as a boon.

The fourth group comprises the people in comfortable circumstances who can afford a private nurse, but who from the nature of the case do not require it.

That the first two groups should be cared for by the public health nurse has always been beyond question. For the third group it has been felt that provision should be made at cost prices, on the ground that it is poor economy for the sick of moderate means to receive nursing care at an expense that will leave them financially crippled upon recovery. So-called hourly nursing done individually has never been a great success, and for this reason organizations serving the first three groups usually place no restrictions in regard to financial standing, but include the fourth group also in their list of patients. Sometimes this is done as part of the ordinary routine of work, sometimes through the establishment of an hourly service for which slightly more than the cost price of a visit is paid, and by means of which a nurse may be secured at a desired hour and for a little longer period of time.

The future financing of public health nursing is hard to predict. As will be seen in the following chapter, it is quite conceivable that eventually it should be entirely taken over by the municipality or state. On the other hand, the growing feeling of responsibility of the employer for the health of the employed shows another tendency, as does the successful experiment of an insurance company to provide nursing for its policy holders. Industrial or health insurance furnishes still another, and peculiarly hopeful outlook, while the increased receipts from patients, seen in all annual reports of private organizations, show a growing willingness on their part to make payment according to their means. Many schemes are on foot in England to place public health nursing on a completely paying basis, and in America the same effort is being tentatively made through the formation of cooperative health societies, but in this country such beginnings are too new to have had as yet any decided effect on the general situation.

Eighth—The principle that provision should be made for an adequate supervision of the nurses' work has become so well

recognized of late years that it may now be classed among those which are fundamental. Supervision implies an advance in the development of any type of work. At an early period supervision is impossible, because no one has sufficiently emerged from the experimental stage to be in a position to contribute anything to those struggling with like problems. As individual workers gain experience from their own failures and successes they are able to be of assistance to others, and gradually as the amount of knowledge increases, it may be so pooled as to be available for everyone. At this point standardization has its beginning, and with it is born the possibilities of supervision, the direction of the work of newer workers by those who are rooted and grounded in these standards and are therefore able to uphold and teach them.

The staffs of the early visiting nurse associations were small and the work far less complex than it is now. The superintendent of nurses was able to give what supervision was considered necessary, and as new nurses were added to a staff they were usually placed under an older nurse who kept an eye on their work in addition to doing her own. Gradually the toll of time thus exacted became prohibitive, and nurses were appointed whose sole duty was teaching and supervision of the work of others. Now, every well-organized staff of any size, whether belonging to a public or private agency, has its group of supervisors as a matter of course, and, if democratically administered, adds to their duties of teaching and supervision a considerable responsibility for the guidance of policy. Though the expense of administration is thus increased, adequate supervision so far improves the quality of the work, and in consequence the return on expenditure, that its advantage is rarely questioned.

If a staff is generalized, *i.e.*, if a single nurse cares for all types of cases, the supervisors for a large staff should eventually include among their number expert consultants in tuberculosis, child hygiene, venereal disease, communicable diseases, and such other types of work as fall within the range of the organization's activity.

It is perhaps too early to be explicit in regard to the amount of supervision which is required per nurse. In the report of the Committee on Municipal Health Department Practice it is

stated that for a staff of fifty nurses there should be at least six supervisors. The ideal number is somewhat higher.

Ninth—One fundamental principle remains, forced upon us in this country somewhat at the point of the bayonet; namely, regulation of the hours of work for the nurse.

In England, where the nurses usually live in district homes, their actual hours of work are at least known. In America such homes are the exception rather than the rule, and many a nurse in her enthusiasm has prolonged her working hours far beyond the prescribed number without the knowledge or interference of those to whom she is responsible even though the efficiency of her work and safety for herself have been obviously sacrificed. The limitation of work to the capacity of efficient accomplishment by the nursing staff is a difficult problem, but whatever means are tried to keep pace with inevitable development, the method of allowing the nurses to undertake more than they can do well within reasonable hours is to be deprecated. Public health nursing in all its branches requires for its performance, not only a body in good physical condition, but a spirit fresh enough to be capable of enthusiasm, that mountain-moving attribute so essential for accomplishment.

Entirely apart from the fact that it is a poor example, and an anomaly, for a jaded, weary woman, or body of women, to be preaching health, it is the poorest possible economy to fail to keep the one essential tool needed for the work in good condition. It is not enough that rules limiting the nurse's hours should be printed in every annual report or list of regulations. Unless such actual limitation is strictly insisted upon, against the amount of good accomplished by public health nursing the ruined health of a worker must be placed on the debit side of the account.

These then may be considered at present the nine fundamental principles of public health nursing:

1. That only well-trained nurses should be employed.
2. That teaching should be considered as important a part of the work of every nurse as the care of the sick.
3. That the rules of professional etiquette should be observed.
4. That cooperation in all its forms should be recognized as of primary importance.

5. That there should be no interference with the religious views of the patients.

6. That suitable and accurate records should be kept.

7. That those who can afford to pay for nursing service should do so according to their means, and that free service should be provided for those who cannot afford payment.

8. That adequate provision should be made for supervision of the nurses' work.

9. That the daily working hours of the nurses should be limited, to the end that good work may be done and they themselves kept physically well.

This number or classification of fundamentals is by no means final. Each year brings changes and developments undreamed of in the beginning, and requiring adaptability of method and administration if progress is to be made.

The almost phenomenal increase, numerically, of the public health nurse is due to the fact that she has met a need. Her ability to meet that need, whatever it may be, will determine the future progress of the work. To do so, much more elaborate machinery will probably be required than in the days when her duties were fewer and simpler; but it must be remembered that all such machinery of organization, public or private, local, national or international, is but a means to an end. The real object of it all is the individual. Numbers of these individuals may for descriptive or working purposes be classed in groups, as school children, tuberculosis patients, or babies, and as such considered as a whole; but it is only as the need of each separate individual in each group is helped to better health, either through instruction or personal ministration, that the public health nursing movement is likely to prosper.

"Large horizons," "broad views" and "far-seeing visions" are never obtained by neglect of detail, and the community whose public health nursing is not built upon the first fundamental principle of honest detail work with each man, woman, and child, though its leaders speak with the tongues of men and angels, is not only as nothing worth, but becomes a stumbling-block to the true progress of the movement.

Chapter 5

MODERN PROBLEMS

Problems are as inevitable to a new and developing movement as are the difficulties that beset the pioneer in a new land. In public health work, as we saw in the last chapter, experience has gradually set experiment into the mould of custom, and old problems have ceased to exist, giving place to established principles.

Had this book been written a few years ago we should probably have found ourselves earnestly considering the hazardous experiment of asking the patients to make payment for their care, or the risk of rendering the nurses conspicuous by placing them in uniform.

Minor problems, some of which are of local interest, others common to the work everywhere, are still constantly arising, but one by one they are being solved by those brave souls who are not afraid of the untried, and whose example is quickly followed by the less venturesome.

There are, however, four major problems which at the present moment occupy the attention of those interested in the development of the movement.

The first concerns the education of the nurse; the second the question of public or private control of the work; the third specialization and its reaction toward generalization; and the fourth the relationship of the nursing profession to other allied professions in the field. These problems with their many ramifications resolve themselves into the question of how the nurse shall be fitted for her work, under what auspices that work shall be done, in what way she shall do it and how it shall be related to that of other workers.

The writer realizes that these questions will be best answered by the knowledge that is slowly being gained by experience. Methods of education are constantly improving, the number of state, county and municipal nurses is increasing, special and

general nurses are at work all over the country and cooperative plans are everywhere being evolved. Time will inevitably show to the open-minded which methods are in the long run productive of the most satisfactory results, but as many a forked road is unheedingly passed, it may be well to point out a few of the aspects of these four problems.

Section 1

Education of the Public Health Nurse

Though early public health nursing organizations took a certain cognizance of the nurse's function of health teaching, until comparatively recent years little was done in this country to fit her for this important duty, or for dealing with those social aspects of sickness that loom so large on the horizon of public health nursing. As a rule she went forth from her hospital, or from the sick-room of her private patient, to struggle alone with problems for which she had no preparation, learning, as the saying goes, "on the job," with all the disadvantages accruing from such a method. True, our grandfathers made experience do the work of training, and the school of experience has graduated many of our finest men and women. It is nevertheless an expensive form of education, and the public health nursing movement can hardly be expected to pass from a pioneer stage into a period of greater usefulness without conforming to the modern method of replacing this slow process by some system of training that will create a standard of efficiency for its workers.

The National Organization for Public Health Nursing since its inception in 1912 has recognized the importance of the educational problem and through its Educational Committee has not only led progressive thought on the subject but has been throughout the country active in the furtherance of educational standardization.

The fact need not be argued that a hospital training as now given, unsupplemented by additional educational opportunity, does not satisfactorily fit a woman for public health nursing. It is admitted by all; and for twenty years effort has been made to provide some form of supplementary training for the public

health nurse. Two methods have been used. Pupil nurses have been sent out from their hospitals for undergraduate training with local public health nursing organizations, and postgraduate courses have been established. The first method, the provision of undergraduate training, presents at present many difficulties. The second, the establishment of postgraduate courses, though having an undoubted effect upon the situation, has failed adequately to meet the need because but a relatively small number of nurses have as yet been able to avail themselves of the opportunities offered.

The insufficient number of properly equipped women, and the rapid growth of public health nursing both as regards volume and scope of work, has during the past few years produced a difficult situation. At the very moment when the new emphasis on health promotion and preventive effort made imperative more highly trained, and differently trained women, the awakened public feeling toward such work demanded a supply wholly out of proportion to all previous experience. As community after community failed to secure the nurse it desired, or in many instances, any nurse at all, it is not surprising that the existing methods of nursing education were widely challenged. Many solutions of the problem of supply and demand were suggested, the most popular perhaps being those involving some form of short cut to the desired end. A number of short-term courses were opened in various parts of the country which claimed to fit young women without previous nursing training for the public health field in a few months of what was usually called "intensive work."

In 1919, when this situation was most acute and the shortage of women entering the training schools as probationers most threatening for the future, a committee was appointed by the Rockefeller Foundation to conduct a study of the proper training for public health nurses. A brief survey brought out the fact that it was impossible to separate the education of the public health nurse from the broader subject of general nursing education, and a year later the scope of the committee was enlarged to include a "study of the entire problem of nursing and of nursing education with a view to developing a program for further study and for recommendation for further procedure."

The findings of this committee have been illuminating and represent a valuable contribution to the subject of nursing education.[1]

When, after nearly three years of waiting the anticipated report was published, the breadth of its scope, and the thoughtful, scientific study that formed a basis for the conclusions drawn, secured for it universal interest and respect. True, it came as a disappointment to a certain number of people who had hoped that the committee would perform a miracle and discover a royal road to nursing knowledge whereby it might be possible to produce well-trained and efficient nurses in a short period of time. Though many recommendations were made by which the hospital training might become more effective and somewhat shortened through elimination of all non-educative work and the reduction of non-educative repetition, nevertheless two years and four months (the working day to be eight hours) was the shortest period of time recommended in this report. For a public health nurse an academic year of postgraduate training must follow.[2]

Undergraduate training in public health nursing in so far as it represents specialized preparation for the public health field was deprecated by the committee on the ground that it is often given at the expense of some of the basic hospital services, and also because so small a proportion of the pupils of any school usually profit by it.[3] It was recommended, instead, that the principles of preventive medicine, and a minimum at least of social interpretation be taught every student before graduation. By reduction of the hospital course to twenty-eight months a postgraduate course of eight months is made possible without increasing the present three-year allotment of time for undergraduate training.

The practical results of such an arrangement have been questioned by some nurse educators who ask if the nurse who graduates from her hospital in this shortened period of time

[1] For a summary of this report, see Appendix.

[2] The Committee, in studying the question of both postgraduate and undergraduate public health nursing training, was in close conference with the Education Committee of the National Organization for Public Health Nursing, and many of the conclusions reached were based upon the joint discussions held.

[3] For further discussion of undergraduate training, see Part IV, Chapter 6.

will actually avail herself of the opportunities of postgraduate work? Is she not quite as likely, they ask, to seek at once a lucrative position and in time drift into public health nursing with no preparation for it? A question also arises as to what constitutes basic training. Perhaps we have too long taken it for granted that the term was applicable only to training in such subjects as can best be taught in a hospital. The time may be coming when greater stress will be laid upon the necessity of teaching those preventive aspects of the health problem that the public health field alone offers. With the development and standardization of public health nursing and with the vastly improved methods of supervision now common, the nursing technique of certain types of work have been carried quite as far as, if not farther than, in the hospital. Nor does the hospital always offer a complete picture of conditions in a given field. All prenatal cases, for instance, are cared for at home. Fifty per cent. of the obstetrical cases are delivered there. The well baby is only found at home. Where are the sick and delicate children and the interesting infant-feeding cases? Certainly not all in hospitals. The same may be said of the tuberculous patients. In these three fields, therefore, of obstetrics, pediatrics and tuberculosis the public health nursing organization would seem to possess a mine of valuable supplementary teaching material barely tapped as yet by the student body. There is undoubtedly a feeling on the part of some training school superintendents that it is impossible properly to supervise student nurses outside of a hospital. This was certainly true in the past; and it is still true in many places, but public health nursing supervision is constantly improving, and at its best already compares favorably with that of any good hospital training school.

True, all public health nursing organizations are not alive to the moral obligation of meeting the educational demands made upon them but there is a growing feeling that escape from such an obligation is impossible and that budgets must be arranged to meet it.

Whatever the future may have in store in regard to the development of facilities whereby part of the basic nursing training may be received outside of the hospital, at present the best entry to the public health field for the graduate nurse is unquestionably,

as found by the Rockefeller Committee, through the door of the postgraduate course. There are in 1924 seventeen accredited courses,[4] covering a wide geographical area and offering varying forms of educational opportunity. The development of these schools is interesting. More than half have been established since 1917. With one or two exceptions the earlier ones were opened by visiting nurse associations, and came into existence for the most part in answer to a demand made by nurses for help in fitting themselves for isolated positions. The unorganized instruction given to the nurse who placed herself for educational purposes on a large staff for an indeterminate period of time had proved the necessity for something better, and the next step was more organized teaching through the establishment of courses of training. As the standard of instruction improved it was further realized that an administrative agency was not the one best fitted to carry alone a purely educational project, and if the courses were to be properly developed they must be placed under auspices better adapted to educational ends. The majority are now offered by universities, and all those endorsed by the National Organization for Public Health Nursing are definitely affiliated with educational institutions of collegiate grade. Since, however, experience in the field is considered an indispensable part of all instruction, and since this is best given by public health nursing organizations, a combined educational responsibility is usually maintained between the educational institutions and the administrative agencies. The financial burden is variously distributed, but there is a tendency for the educational institutions to assume primary financial responsibility and direction, with assistance from the public health nursing agencies for field work and often for field supervision. Advisory committees composed of representatives of the two affiliating bodies with additional representatives from the League of Nursing Education, the health authorities, the other agencies offering field work and such lay individuals as the local situation may suggest, are now considered essential to the sound management of a course.

All postgraduate courses are naturally dependent on the standards maintained by the educational institutions that feed

[4] Endorsed by the National Organization for Public Health Nursing.

them, and public health nursing courses have been placed at a disadvantage by the low entrance requirements hitherto maintained by most hospital training schools. It has been found that it is difficult to give a satisfactory postgraduate training to students who have not had at least the equivalent of a high school education, yet the demand for exceptions to this necessary rule is in many localities insistent, since the majority of hospital training schools have required but two years of high school for entrance, and not always that. The Rockefeller Committee therefore attacked the source of the difficulty, and recommended high school graduation as an entrance requirement for all hospital training schools. This, if generally adopted, will relieve the postgraduate schools of a decision between undesirable concession or a refusal of applicants which limits their opportunities for usefulness.

Through affiliation with schools of nursing some of the universities offer five-year courses, two years of academic college work, two of general nursing training, and a fifth year in which the usual public health postgraduate course may be elected. At the close of the fifth year a bachelor's degree is awarded, in addition to the nursing diploma.

The National Organization for Public Health Nursing lays down a few general principles to govern the establishment of public health nursing courses. These represent minimum requirements and are as follows:

1. The direction of such courses shall be provided by a college, university, or other school of collegiate grade, which will allow academic credit for matriculated students.

2. The director of such a course must be a nurse who has had experience in Public Health Nursing and who is competent to teach and supervise Educational work. She is the person actually responsible for the standard of work both didactic and practical. It is highly desirable that she should be a college graduate, and where her appointment is in a college or university, this requirement is almost a necessity. Responsibility must be vested in the Director who in case she has other duties will make adequate provision for the proper conduct of the course.

3. The minimum time required for a course leading to a certificate is an academic year of which about half should be given to didactic instruction and about half to supervised field work. Periods of training composed chiefly of field work of not less than four months may be

given, but no certificate should be granted. Such a four-months period can be considered a unit towards the full eight- or nine-months course, provided the student is eligible for the full recognized course.

4. Didactic work shall be offered in subjects dealing with nursing, social, teaching, scientific and medical problems. The social subjects should include such courses as deal with social case work, and the scientific basis for the treatment of social problems; nursing subjects—public health nursing in its several branches, organization and administration; teaching,—psychology normal and at least an introduction to abnormal; preventive medicine—prevention and control of disease, public health administration and sanitation, family nutrition and budget planning.

5. Field work shall be given only in connection with previously established organizations which can provide adequate supervision and personnel, a sufficient volume and variety of services, and whose methods are good. The various phases, as general Visiting Nursing, School Nursing, Tuberculosis and Child Welfare Nursing shall be carried on according to sound principles of public health nursing, the promotion of health, prevention of illness, care of the sick. Social case work shall be practised under the supervision of a trained social worker in connection with a well-organized social agency. Sound principles of cooperation with other community organizations shall be taught and practised.

The question of the balance of theoretical and practical work has received much careful study, and it is now felt that the usual principle of vocational education that approximately equal time be given to technical and practical instruction is applicable to public health nursing and should govern the conduct of the courses. For field instruction two methods are in general use. Students may be taught in the ordinary districts of a public health nursing organization, or a section of the city may be reserved as a practice field. The specially reserved teaching district has its advantages and its disadvantages. Where it exists, teaching is undoubtedly simplified and the student is enabled to study conditions more nearly as they ought to be, thus gaining a model conception for work in her later experience. On the other hand a teaching district is liable to become an artificial unit, and the conditions made so unnaturally favorable that they will not be reproduced elsewhere. Under these circumstances the student gains impressions that must be unlearned with considerable difficulty after graduation. Unless, too, a teaching district is sufficiently staffed with graduate nurses, there is danger either

of exploiting the student for the work that she does, or of slighting the patients in the interest of an educational program the very object of which is defeated by such a course. It has also been found that segregation of the student group is undesirable and that more is gained from a free mingling with the regular staff of the organization.

In addition to the courses occupying a full academic year there are others covering a period of four months. These shorter courses when complete in themselves, and not merely an introduction to a longer one, have as a rule been offered by nursing organizations and not by universities. Their value is considered questionable by many, though others believe that for the present at least they serve an important purpose and meet a very real need.[5]

A discussion of nursing education would have no place in a chapter entitled Modern Problems, if the last word on the subject had already been said. The invaluable work of the National Organization for Public Health Nursing and the Rockefeller Committee have taken us a long step forward in understanding the problem, and we are no longer, as in the past, groping in the dark. On the contrary we have a distinct goal toward which to press. Nevertheless we must face the actual facts of the present situation.

There are approximately twelve thousand positions now filled by public health nurses, only a comparatively small percentage of whom have had the advantage of special public health training. Though the number of graduates of the courses is increasing, this increase is by no means commensurate with the annual rate of increase of public health nurses.[6]

This is the numerical situation. How rapidly can we hope for improvement? From the point of view of a general accept-

[5] The name course should probably not be applied to anything short of an academic year of training.

[6] It is impossible to tell the actual number of graduates now at work, because of the earlier lack of standardization of the courses. During the year 1922–3, there were 22 students registered in a two-year or more course, 159 taking the academic eight- or nine-months course, 13 in six-months courses, 70 plus in four-months courses, and 79 nurses in part time in the departments (statistics obtained from the National Organization for Public Health Nursing).

ance of a higher educational standard we again meet with unwelcome facts. Very few hospital training schools have required more than two years of high school from their applicants, and some less.[7] We have therefore hundreds, if not thousands, of nurses doing public health work who would not qualify for a postgraduate course, as well as thousands of others in like case in the nursing field at large, from which recruits are drawn. It is an undoubted fact that training schools will move but slowly toward radical change, and it is equally certain that, even granted eligibility, the great body of nurses will not for some time see the necessity for postgraduate work, or will find the expense involved prohibitive.

The actual situation therefore is this. We know that we have a certain volume of work to be done, we have attained to a fair degree of standardization as to method and procedure, and we have more or less knowledge of the preparation required for the worker. On the other hand we have a wholly inadequate number of workers so prepared, and from every indication it seems probable that considerable time must elapse before this state of affairs can be remedied. What in the meantime shall be done? Three lines of action seem open. First, we may discontinue all work for which we have not an adequately prepared nurse, and at the same time refuse to inaugurate new work without such provision; second, we may continue under present conditions, in the belief that in time the old order will be changed, and that if the right kind of incentive is provided nurses in sufficient numbers will eventually be supplied from the postgraduate schools; and third, while awaiting this end we may strive to give, in addition to the educative supervision already common, a minimum of theoretical instruction to the great body of nurses already at work.[8]

No one goes so far as to advise the wholesale abandonment of the many pieces of good work which are at present being done by nurses who are without the desirable educational preparation. We may therefore dismiss the first course suggested

[7] "There are seventeen hundred schools of nursing in the United States. A few over two hundred have established high school graduation as a minimum requirement." News Bulletin of the Bureau of Vocational Information, January 1, 1924.

[8] See Part IV, Chapter 6.

without discussion. The second has many advocates who feel that if no half-way measures are adopted, but if on the contrary wise and constant pressure is exerted, the day will be hastened when all nurses who desire to enter the public health field will expect to fit themselves for it as a matter of course, as do the members of other professions for whom no free vocational training is provided, and for whom an apprenticeship system does not exist. Advocates of the third course, while admitting the danger of prolonging the present situation through the employment of palliative methods, feel nevertheless that more is to be gained than lost by submitting to the exigencies of the moment.

Examples of these divergent points of view are to be found in two of our largest and best organized public health nursing organizations, the Directors of which are identified with all that is best in nursing education. Both organizations are affiliated with educational institutions in giving postgraduate courses. In one the policy is maintained of admitting to the staff only nurses who have taken at least a four months' public health course, and this in spite of the fact that there have never been enough with these qualifications to complete the requisite number. A third or more of the staff must therefore be made up of so-called substitutes. In this organization the number of nurses eligible for staff membership is steadily increasing, and it is felt that the pressure thus brought to bear is proving of definite value in raising the educational standard throughout the state.

In the second organization it is thought better to make no such requirement, but instead to consider all new nurses who have not already taken a course in the light of students, and to give to each the unit of training given the pupil nurses (two months). A postgraduate course (nine months), though naturally encouraged for all, is required for supervisors only.

Advocacy of these two points of view will depend somewhat on local conditions. In some parts of the country a requirement of postgraduate training is quite reasonable, in others extremely difficult of attainment or entirely impossible. On the whole the educational committee of the National Organization for Public Health Nursing has been inclined, to advocate in the light of the present shortage of well-qualified nurses, a distribution of

the graduates of postgraduate schools to positions of leadership and supervision or to organizations where a single nurse is employed and where, in consequence, no supervision can be furnished.[9]

If this is to be so, and if for the present average city organizations are to be staffed with nurses who enter upon their work without special training, and in many instances without previous experience, how can they best be helped to proficiency without prohibitive loss of time? Well-organized supervision of daily routine, taken in conjunction with the usual staff conferences and such lectures and talks as are provided, has had its effect; but a marked gain in progress has been noted where a few weeks of carefully arranged theoretical instruction has been added to these accepted methods. In advocating theoretical instruction for the staff or pupil nurse let us not be misunderstood. No solid block of theory is advised. Indeed a weekly maximum of six hours of theoretical work taken in conjunction with the field experience is all that is recommended by the Educational Committee of the National Organization for Public Health Nursing.[10]

The rural and small-town situation presents greater difficulties than the urban, and though theoretically no nurse should undertake work alone without a minimum at least of preparation for it, it is a well-known fact that many nurses are now working who have had no preparation whatever. Even where supervision is provided, something in the way of definite teaching is required. A number of the state health departments have recognized this necessity, and provide for special training for their nurses.

The so-called institutes, or courses of lectures and conferences arranged in various parts of the country, fill a distinct need for nurses already engaged in public health work, for by this means it is possible to keep up with modern methods and gain the stimulation often so sadly lacking.

Whether suitably safeguarded correspondence courses will

[9] The committee also advocates the development of programs for staff education under the direction of qualified graduates of postgraduate courses.

[10] The committee recommends a weekly minimum of four hours of theoretical work.

eventually be arranged to fill a like need for nurses now at work remains to be seen.

The problem of public health nursing education is perhaps nearer solution today than it has ever been before, because we know as we have never known in the past what we are trying to obtain. On the other hand there is, as we have seen, enormous divergence between the academic and professional preparation thought desirable for the public health field and that which it is possible to require of the great body of public health nurses.

It is felt by the Education Committee of the National Organization for Public Health Nursing that in a consistent raising of their academic and professional requirements by organizations employing nurses, and the establishment by administrative bodies of definite educational programs for their staffs, lies the best hope of meeting the present need. Meanwhile it is an encouraging sign that nursing education is receiving a general interest never before aroused, and that on the whole the young women entering the hospital training schools seem to be increasingly qualified for advanced instruction.

Section 2

Private or Public Control of Public Health Nursing

The second major problem, that of the desirability of municipal or state control of public health nursing, is one which in the past affected principally the special branches of the work, but which now, owing to the increase of generalized nursing, affects the entire field. At the same time the position of the privately administered organizations is in many ways stronger today than it ever was before. They have an increased earning capacity, as well as an increased power of obtaining funds by other means; their business standing is steadily increasing, and years of conscientious effort have earned for them a public confidence which has not been lightly won. In other words they are at the present moment in a position to do their best work. The question therefore of complete relinquishment to public agencies is one requiring thoughtful study.

It is probably to be expected that a public opinion which

countenances present legislation on child labor, hours of women's work, housing, etc., and which in some cities goes so far as to advocate municipal ownership of street cars, telephones, ice and storage plants, recreational equipment and other so-called public utilities, should also stand for a very complete assumption of governmental responsibility in matters of health. Because this is so evidently a trend of the day the problem should receive more than a casual consideration lest, on the one hand, unconsidered action undo the work of years, or, on the other, progress be retarded by failure to realize that the cause of public health nursing, like other causes throughout the ages, is best served by different means at different times.

An extensive study of municipal health work has recently been made by the Committee on Municipal Health Department Practice of the American Public Health Association, and in the report of this committee a chapter is given to the subject of public health nursing. The opening sentence is suggestive. "The task of analyzing municipal health department practice has proved a sufficiently difficult one in all its aspects, but nowhere else are the difficulties so great as in the field of public health nursing. In the first place we find the activities of public and private agencies overlapping and intermingling in this field to an extraordinary degree; and in the second place different cities exhibit a wide diversity of opinion as to the nature of the work to be performed by the public health nurse."[10]

Could lack of standardization be more strikingly described?

The often inelastic methods of governmental bodies seem to many an insuperable drawback to their administration of a new and actively developing work like public health nursing; and there are many also who tremble at the dangers evoked by that dragon of uncertainty vaguely known as "politics," a dragon which seems to them but lightly chained, and which stands ready at any moment to break loose and demolish the good that has been already accomplished. There are others who feel that since, theoretically at least, health is a state responsibility, no time should be lost in turning over to the state this

[10] Report of the Committee on Municipal Health Department Practice of the American Public Health Association, prepared by C.-E. A. Winslow, Dr.P.H., and Margaret R. Burkhardt, R.N.

responsibility in full. The former group would have all private agencies hold tightly to their prerogatives, fighting, if need be, for the right of protection from state or municipal interference, the latter group would lose no time in stimulating public authorities to recognize and assume this duty.

Between these two groups of extremists are two others, one feeling that eventually all public health nursing work should be publicly administered, that it is not only theoretically right that this should be the case, but that practically also it will bring about a better form of administration. They advocate, however, a gradual turnover, feeling that any immediate wholesale relinquishment of private initiative would be untimely, and disadvantageous to the best progress. The fourth group is in its present outlook at one with the preceding group, but in regard to the future presents a distinct difference of opinion. This fourth group though readily granting the responsibility of the state for public health, believes that not only now, but in the future, there is a place for the private organization, a place that can never be filled by even the best and most carefully administered public agency.

Those who fear the dangers of public administration usually do so on the following grounds: *First,* that states and municipalities are in many instances unprepared for such responsibility. That in consequence there is too great sacrifice in their assumption of it, and even when the best intentions exist, the loss of momentum involved in turning over a carefully guided piece of work to unaccustomed hands is too great. *Second,* that public bodies are only in rare instances ready to make use of the valuable contribution of time, thought and enthusiasm now rendered to private organizations by interested citizens, and that without such safeguard, so-called political interference becomes more or less inevitable. *Third,* that governmental bodies do not always so organize their work as to attract and retain the best type of professional worker. *Fourth,* that a change of political administration may at any time completely reverse a constructive policy.

The arguments for public control readily present themselves: *First,* that no private body can ever so hope to expand as to cover the entire field of public health nursing, and that financial

support for such expansion is not likely to be forthcoming. *Second,* that private agencies do not exist, nor can they be brought into existence, for any adequate handling of the work in rural communities throughout the country. *Third,* that through private initiative alone health education in its broadest sense will never be placed on a par with other forms of education. *Fourth,* that as a matter of practical administration certain forms of public health nursing, notably school nursing, are inevitably connected with the work of municipal boards of health or education, and that it is therefore not logical so widely to separate responsibility for the health protection of an individual by an arbitrary line drawn between his sixth and seventh year.

It is conceivable that nursing care, and health education, may eventually be brought to all citizens through insurance for which they themselves will pay as surely as through taxation, but over which they will exercise more direct control, since competition will inevitably furnish alternative propositions in the placing of policies.

One element is at work to increase the effectiveness of state, county and municipal nursing, namely, the better type of education now being given to health officers in the new schools of public health. With standardized methods, appointments must inevitably be less influenced by politics, and with more trained men in charge of the departments of health who understand the possibilities of public health nursing, there cannot fail to be a better basis for progress. The excellent work now being done by public bodies, under the widest possible diversity of conditions, would certainly seem to justify the present very evident trend of opinion toward public control. That the very highest standards have in this way been attained is open to question.

In the study of public health nursing in eighty-three American cities, made by the Committee on Municipal Health Department Practice of the American Public Health Association,[11] it was found that a greater amount of supervision per nurse was being

[11] Report of the Committee on Municipal Health Department Practice of the American Public Health Association, prepared by C.-E. A. Winslow, Dr.P.H., and Margaret R. Burkhardt, R.N.

furnished by the private agencies.[12] It was also found that only in about half of the public agencies studied, was the work coordinated under a single nurse director. These facts, though requiring remedy, need not necessarily mitigate against public control, for adequate supervision and able nurse directorship are perfectly possible for any state or city agency.

Perhaps the greatest and most fundamental difficulty lies in securing, in behalf of a public body, groups of interested and well-informed men and women to correspond to the excellent boards of directors which guide the policies of most private organizations. With such groups following each detail of policy, and at the same time leading and expressing a wider community public opinion, many of the drawbacks to public control are removed.

The problem is no simple one, and there are many practical details that enter into it; among them the question of generalized and specialized methods of work, discussed later in this chapter, is involved. Certainly before the private agency can be permitted to go out of existence, public agencies must be brought to see the importance and necessity of purely alleviative work, for no community is properly served that cannot command in addition to health education, an adequate nursing service for its sick and helpless.

Perhaps the function of the private organization of the future will be found to lie in supplementing the work of public bodies; in starting, and later when practicable relinquishing, pieces of work; in emphasizing special phases or points of view; in checking, by parallel efforts, standards of technique; in making daring excursions into untried realms; for there is no doubt that a private agency is peculiarly fitted to enter experimental fields, thus securing, through elasticity of method, experience in

[12] A further study made by the Provisional Section on Public Health Nursing of the American Public Health Association regarding the qualifications required for superintendents and supervisors in the private and public organizations in these 83 cities showed that in the 68 private organizations reporting, the ratio of nurses to supervisors was 8 to 1 as against 14 to 1 in 69 public organizations. Brief Report of the Provisional Section on Public Health Nursing, American Public Health Association, *Public Health Nurse*, January, 1924.

new lines of work, and so furnishing to public bodies out of that experience both example and warning.

Section 3

Generalization and Specialization

The third problem, that of the advisability of specialization in nursing, is one about which there is great difference of opinion. Miss Ella Phillips Crandall describes the growth of this tendency so well that I quote her words: "The present highly specialized service of public health nurses is a logical, if not an inevitable, result of the gradual growth of public consciousness and conscience regarding better standards of living in general and of health in particular. The tuberculosis nurse came as part of the world-wide campaign against tuberculosis, the school and infant welfare nurse in response to the demand for a fair start in life for infants and children, the medical social worker as an indispensable factor in the practice of preventive medicine, and the industrial nurse as a part of the employer's effort to keep his most valuable asset, the workers, in the best possible trim."

We hear much of the disadvantages of duplication of work due to specialization. The story of the family whose five members were visited by five nurses because each patient required special advice or care is both picturesque and telling, but the detail of duplication is not the most important point in the question of specialization. The main issue is whether the people, individually and as a whole, now and in the future, will be better served if public health nurses specialize, as do the doctors, in certain lines of work. Both specialization, and what, for want of a better word, has been termed generalization, have their weak points; and in considering the subject we shall do well to separate the weaknesses that are inherent parts of the method, and those which are due to poor administration. With all due regard for dangers and limitations, each must be judged by its possibilities under the best possible administration.

That a multiplication of nursing agencies in any city is undesirable is conceded by everyone, and the tendency of the day

is quite obviously toward an amalgamation which, if continued, will in time produce a single staff of public health nurses for each city. Unquestionably at the present moment the trend is also toward complete generalization of such staffs, whereby all types of cases will be cared for in a small district by a single nurse supervised and directed by a group of specialists who will act as consultants, and who will represent expert opinion in their various fields. Unfortunately for purposes of study few cities have been completely generalized, and none for a sufficient length of time to enable us to judge fairly of results. Complete generalization, such generalization as is carried on in small towns or rural districts, is extremely difficult of accomplishment in larger cities where as a rule the work of several agencies must be amalgamated, a process involving an infinite variety of delicate adjustments. Some time must therefore elapse before we shall have the advantage of studying, even in their beginnings, any number of completely generalized city ventures, and still longer before relative advantages can be properly weighed in all their various aspects. Meantime the findings of the Rockefeller Committee for the Study of Nursing Education are extremely interesting.

For this study forty-nine public health nursing organizations were selected in thirty-three communities,—urban, rural, public and private agencies being included. Twenty-eight of these organizations covered more than one field of service. Twenty-one confined themselves to one field. In her report Miss Goldmark says: "In the course of our investigation the advantages for preventive work of generalized nursing, as opposed to specialized, were repeatedly and unmistakably demonstrated." Though Miss Goldmark makes mention of certain practical details, such as the saving of time between cases in the small generalized district, and the avoidance of a multiplication of departmental details, her conclusions are based for the most part on broad underlying principles. She wisely emphasizes the importance of the approach to the individual, and puts her finger at once on the vital question of how best to create an attitude of receptivity. "The essence of this problem," she says, "is plainly the approach to the individual, the contact. How among the vastly increased conflict of motives, interests, and objectives

in man's modern life, shall we obtain for a given idea that degree of attention which is needed to give it some degree of permanence, and to release its dynamic power? How shall we combat for a given object not only mental inertia—the natural human inclination to think only when we must—but also the active opposition of natural human prejudices in favor of our own way of life, however mistaken?" Continuing, Miss Goldmark says, "This then is the fundamental lesson which, starting with no preconceptions, and no brief for any system of nursing, our field study has brought home to us. This is, in our opinion, the strength of generalized nursing, combining bedside care and instruction as against instruction alone, that it offers a natural, and unforced approach to the individual and the family, because it is itself sought. It works with, instead of against, deep ingrained instincts of normal adult life. The instructive work of the generalized nurse starts from this vantage ground. Her concern for the health of the entire family further reinforces this initial advantage. Each member of the family whom she can aid by nursing care and advice adds to the sum of her influence. With the instructive nurse, on the contrary, each member of the family whom she must refer to another nurse, for nursing care or for instruction in a different specialty, detracts from her influence."

Miss Goldmark frankly admits the dangers of the encroachment of bedside nursing on instructive visiting. "It is true," she says, "as illustrated in various visiting nurse associations giving bedside care, and it should be admitted at the outset, that the weakness of generalized nursing often lies in its too great emphasis on curative work alone, to the detriment of the preventive. The necessary supervision of well babies, for instance, may suffer when pneumonia is unusually prevalent. Yet to admit this weakness is not therefore to deny the theoretical and practical benefits of the generalized system. The possible overemphasis on curative work is in our opinion a failure of administration, not of principle. It is the result of attempting in the generalized system to cover too large a territory with an inadequate force, or without the proper supervision by specialists, which is admittedly indispensable to keep true the balance between the kind of services rendered." Miss Goldmark further

says, "But even admitting that the curative work of the generalized agency may tend at times unless carefully guarded against, to overbalance the instruction, nevertheless in our opinion the advantages of the system far outweigh its possible weaknesses. The bedside care it offers, and its stress on a local unit of work for each nurse, are, in our opinion, irreplaceable assets, opening doors to the nurse at which she knocks in vain with instruction only."

It will be seen from the foregoing that after prolonged study the committee gives practically unqualified approval to the generalized form of nursing, and to this opinion the majority of leading public health nurses will perhaps subscribe.

Experimentation has its value, and the present widespread effort to generalize work which has been far too highly specialized cannot fail to result in good. Conclusions are, however, as yet by no means certain, and a very real danger lies in a premature abandonment of all specialized forms of nursing, not alone because of local results, but because of the effect on the special fields themselves. In the light of a long experience in a city where special work has for years been carried on under a single organization, the author feels that this method has not, elsewhere, been given a sufficient trial. A multiplicity of agencies, each with its own staff of nurses, must fail in any city. Overhead expenses are doubled or trebled, good cooperation is difficult, rotation of nurses is impossible, a just balance of the relative importance of effort cannot be secured, the patients differentiate between the various uniforms and what they represent, and all these things act and react until the patients feel at every visit the result of creaking wheels. Where, however, a single agency controls the situation, overhead expense is reduced, a single policy controls the work, cooperation between the nurses can be carried to the furthest point, free rotation through the services which will secure a rounded point of view is easy, intimate knowledge of each demand in its relation to all other demands conduces to a wise apportionment of funds, the single uniform stands for a universal helpfulness no matter who wears it, and the community learns to lean on the strong arm of a united body. At the same time the encroachment of acute necessities on instructive work is avoided, stimulation of the

various groups is assured by mutual interest, knowledge and proficiency are increased through undivided attention to a special subject, a valuable field for teaching is secured through the volume of cases of a given type segregated, and special studies and experimentation are made easy. In considering the many advantages of generalization, these advantages of specialization must not be lost sight of.

It is in the light of daily experience that we must eventually judge of results, and the question of generalization in nursing requires continued study and analysis. Such study and analysis must not be restricted to a few students of public health nursing. Every nurse in the field can help to solve the problem by continually asking herself certain questions.

The specialized nurse may ask: Do I know my neighborhood and my families as well as the generalized nurse? Am I looking at my family as a whole, missing no opportunity of helpfulness? Is advice unconnected with bedside care unwelcome? Is my influence weakened by reference to the more expert knowledge of another nurse on some special subject? If so, would it be the same if the other nurse were a member of my own staff wearing the same uniform? Is there a multiplicity of administrative detail which could be obviated by working under a single agency? Is my first contact with the patient more difficult than that of the general nurse?

Let the generalized nurse ask herself, equally searchingly, a similar set of questions: Is my tuberculosis work, my baby work, my venereal disease work, my mental hygiene work, as good as that of the special nurse who is doing it elsewhere, or who formerly did it here? Does my instructive work suffer unduly from the pressure of my bedside nursing? Am I really keeping abreast of the newest thought in all the branches of nursing which I am undertaking? Does natural interest lead me to an unbalanced distribution of my time and thought? If I am not able personally to attend the clinic to which I send my patients, how much do I miss in not doing so?

It is upon the thoughtful answers to such questions as these that we must depend for the final solution of our problem, and there are still other questions, somewhat removed from the daily experience of the individual nurse, which boards of managers,

executives and teachers must be prepared to face. For instance: Is any time or money being spent for overhead expenses, transportation, or salaries which could be saved by a different form of organization or administration without loss to the development of the work? Are the nurses working in a way satisfactory to themselves? Is the interference with instructive work caused by the pressure of bedside nursing an emergency situation which is likely soon to be changed, or is it in reality one that is more or less chronic, due to the fact that few cities have, or are likely to have, a staff equal to the rapidly increasing demands of preventive and instructive work? Has the generalized nurse the time to reach the type of case which requires earnest seeking, as, for instance, the young man or young woman suffering from venereal disease, who is migratory and who feels no need of help? Is there danger that the standards of specialized types of work may slowly and imperceptibly decline when the influence of the large groups of nurses now giving to them a primary interest is withdrawn? Will the special consultants receive sufficient stimulation when they alone on a staff are responsible for the development of their special line of work?

The educational opportunity offered for training nurses under the different systems is also important. It may be asked, does every nurse under the specialized system get a sufficient insight into all the different types of work to round out her training, and can she be taught to visualize the family as a whole? Under the generalized system does the small district provide a sufficient volume of cases of different types to prove broadly educative? When no specialties exist where and how will the consultants be trained?

Advocates of generalization lay special stress upon two points: first, the advantage of a background of bedside nursing in making the first contact with a new patient, and second, the greater intimacy with the people of a small district gained by the nurse who serves it alone. Both these points require further study under systems of generalization. It will be interesting, for instance, to know the number of families which are visited for instructive purposes only, and also the number visited first for this reason. Instructive visits are increasing more rapidly than nursing visits in most communities, and this is likely to

continue to be the case, because an instructive visit represents in many instances a normal family situation, a nursing visit an abnormal one. In view of this, is the importance of the fact that a nurse also gives nursing care in case of illness perhaps overestimated? The second point, the intimate acquaintance of the generalized nurse with the people of her small district, also requires study in view of the actual labor turnover in most large staffs. Apparently permanence of staff is decreasing rather than increasing, owing to the demands of the field and also to the rather different type of young women now at work. Moreover, a too permanent staff is not desirable. Before staking too much on this point, therefore, we should know what is the average length of service of a nurse in a given district.

Perhaps the crux of the whole situation lies in the difference of opinion as to the possibility of properly preparing general nurses for all types of work. Advocates of both methods are eagerly watching the experiments which are being tried in various cities to generalize work that has previously been carried on under groups of special nurses. The results of such experiments cannot be justly estimated in any short period of time, and hasty conclusions must, as we have said, be avoided. Nevertheless, each development of these experimental efforts is instructive and enlightening. The development of the health centers, through which are coordinated all the health activities of a district, both medical and social, is another experiment which is likely to be illuminating. The health centers cannot yet be said to have passed an experimental stage, for they have nowhere been established in sufficient numbers actually to meet the needs of any city. Nor do they necessarily mean a generalization of nursing work, though the tendency is undoubtedly away from specialization. Well-administered health centers form excellent laboratories for the trying out of many health experiments, not least among them the best method of bringing public health nursing to both sick and well.

So complex is the entire question, and so various its many aspects, that a brief summary of the two points of view may be helpful in closing. The following are the arguments usually advanced by those who believe in generalization:

First, from an economic point of view, that an unnecessary amount of money is spent both for transportation and for time when more than one nurse covers the same territory.

Second, that the best approach to the family is made by the nurse who enters in response to a call for help in sickness, or who is known to give bedside care as well as instruction. Also that the entrance of several different nurses into a household tends to weaken the influence of each.

Third, that the constant presence in the small district of one nurse so familiarizes her to the people that they learn to call upon her readily for advice in health as well as in sickness.

Fourth, that for the average nurse variety of work acts as a helpful stimulus, and that the monotonous round of similar duties performed day after day cannot fail to react badly upon her, and in turn upon her work.

Fifth, because as each individual phase of disease more and more comes to be recognized as a part of the whole public health problem, requiring treatment as such, specialization should be avoided as tending to delay, or prevent, such general recognition.

Sixth, that the excellent work long done by single nurses who work alone in small towns or rural communities proves that the various branches of public health nursing can be successfully dealt with by one nurse.

To those who believe that the greatest progress is to be made through specialization the foregoing arguments are unconvincing, for it is felt that the same reasons that have led to specialization in other kinds of work, lead, and ought to lead, to it in the field of public health nursing.

If it is true that the doctor who spends his time in studying one form of disease becomes more expert in that disease than the general practitioner, and makes a greater contribution to the accumulated knowledge of the subject by carrying such knowledge farther than would be the case if no specialists existed, why, they argue, should the same not be true of the nurse who works shoulder to shoulder with him, giving her aid not merely in the intelligent care and instruction of the patient, but by adding her quota to the existing knowledge of the nursing side of the question? That sacrifice must be made for this great

gain is admitted, but that it is of such a nature as to make advisable the retrograde step of a return to the "general practitioner" alone, in nursing, is denied.

The *first* argument concerning the unnecessary, and therefore unjustifiable, expense involved in carrying on special lines of nursing by means of separate groups of nurses, is met by a frank admission that such expenditure can be justified only by a corresponding gain in efficiency. The waste involved in the duplication of overhead charges is not, however, necessarily considered a part of specialized work, for its most ardent supporter would urge the grouping together of the various services under one central organization, thus avoiding this difficulty.

The *second* point, as to the advantage to the patients of the single nurse who gives bedside care as well as instruction, and whose advice and influence in the homes is not weakened by that of other nurses, is thought to be open to question. Instruction in matters of health is more generally sought than formerly, and, in the experience of many, the nurse who brings this is quite as welcome as the one who brings the tangible service of bedside care. Moreover, occasionally in the multitude of counselors wisdom is to be found, and one personality is able to succeed where another has failed, presupposing, of course, a cooperation which will prevent conflicting advice.

To the *third* argument, that the presence of a single nurse in a district so familiarizes her to the people that they readily call upon her at all times, all would agree, were the single nurse always ideal, and removed from the human necessities of vacations, and sick leave, or the still more disastrous possibility of marriage or removal. Since, however, say the specialists, the ideal nurse is hard to find, and even when found is by no means permanent, does not greater strength lie in the reliance by the patients and the people of the district on what is represented by the uniform, rather than in a faith which is pinned to a single personality?

The *fourth* point, regarding the monotony of work for the nurse who specializes, is of importance, but though the majority of nurses might prefer the small district with the greater variety of activity, others, it is thought, are glad to eliminate all but a single type of service. Where, too, the special branches are

controlled by one organization, a nurse may be rotated through the different services, thus varying her work before any touch of monotony reacts unfavorably upon her.

The danger expressed in the *fifth* argument, namely, that specialization tends to foster a microscopic examination of a single aspect of a family situation, thus obscuring the problem as a whole, is felt by everyone to present the strongest objection to specialized work. It is a danger common to all forms of specialization, and can be avoided only by a broad-minded grasp of public health nursing as a whole, and a spirit of cooperation which will work for all-round accomplishment. In it, however, lies a recognized menace, and one which should not be lightly passed over.

The *sixth* assertion, that the excellent work done by nurses working alone in small towns or rural communities proves the ability of one nurse to deal with the various aspects of such work, is granted. But on what foundation, it is asked, does her work rest? Is not a part at least of her success due to the fact that special nurses, in perhaps far-distant cities, have carried the technique of the special branches farther than she would have been able to do, and that it is on that advanced knowledge that she is acting?

In summing up it may be said that the greatest drawbacks to specialization lie in the danger that a broad grasp of health problems may be missed, and that the patients may suffer from an unnecessary invasion of their homes by a number of nurses whose combined influence is less than that of a single individual. These are objections not lightly to be met by those who urge a wise specialization.

An open-minded readiness to admit a mistaken position, with an equal readiness to retrace steps taken on a wrong path, should mark those genuinely interested in the welfare of the public health nursing movement.

No plea is made for either method by the writer, who believes thoroughly in all forms of thoughtful experimentation. She would only urge continued study, and such deliberation of action as will prevent loss to the special services of a momentum which has been the result of years of painful acquisition.

Section 4

Professional Relationships

Many currents run into the river of progressive thought, swelling its volume and increasing its power, but not infrequently causing difficult navigation at the points of confluence. Such a current is that which is bringing to the main stream of social betterment new varieties of professional workers.

In the old days a nurse had few professional relationships, indeed none except those with physicians. True, she touched lightly the church visitor and the charity agent, but there was little debatable ground between her own activity and that of these workers. Cooperation usually took the uncomplicated form of requests for simple material relief on one side, and nursing care on the other. Little adjustment was required, for the nurse did not expect to give relief and the charity visitor did not expect to do nursing. When, however, both workers began to delve below the outward evidences of social and physical distress in search of an underlying cause, they found themselves upon debatable ground; for in many instances the cause discovered was the same, and the question of who should deal with it arose. As standardization in both professions has replaced earlier experimental effort, and as the representatives of each have availed themselves of an increased educational opportunity, thus learning to spend more time and thought on common causes, the public health nurse has found herself confronted with many new adjustments of her duties and responsibilities. Nor has development stopped here. To the doctor and general social worker are now added other new professional workers,—the health educator, the nutritionist, the industrial and psychiatric social worker, the occupational therapist, and others, —all trained men and women engaged in fields closely allied to her own, and covering ground some portion of which at least might easily be considered as falling within her own radius of activity. The question of the apportionment of responsibility arises a thousand times. At what point shall a social worker be called in to make a plan for family rehabilitation? Where does the work of a medical social worker begin and that of a public health nurse

end? What relation shall a school nurse bear to general health questions in a school? Shall an industrial nurse go beyond the first-aid room of a factory served by an industrial social worker? Shall the nutritionist act as a consultant to nurses working in the homes, or shall she herself make home visits for purposes of family instruction? If nursing care is not required shall a nurse continue oversight of a family visited by an occupational therapist? In addition to these questions which involve individual contacts, there are others of general community interest. What, for example, is the legitimate part of a public health nursing organization in a health program that includes the activities of all of these groups of workers?

In any consideration of these problems two tendencies must be reckoned with: first a tendency toward a higher standard for all types of work, which presupposes more intensive and highly specialized preparation for the worker, and second a tendency toward a revulsion from this idea and a dread of a wholesale invasion of the homes. The first tendency, if followed far, will lead to a gradual withdrawal on the nurse's part from a number of activities at present considered within her province, and will prevent her entrance upon other paths now opening or likely to open before her. The second tendency, if followed to the same extent, will lead to an assumption of responsibility probably beyond the powers of any single individual, the preparation for which would require years of study.

It is impossible to do more than point out the essential features of this problem, for the course of future development is too uncertain to warrant prediction of any kind. Nurses, however, must not close their eyes to certain facts. Obviously they cannot do justice to the various demands of health work with their present equipment of preparation. Though many nurses in the absence of other professional workers combine a variety of duties with those of public health nursing, it is highly improbable that nurses will ever become as good social workers, as good health educators, as good nutritionists, or as good occupational therapists as those who have been trained for these activities alone.

The best health program would seem therefore to require a number of professional workers, and the problem resolves itself into a question of the delimitations of the work of each. What

fields shall the public health nurse relinquish in favor of other workers? What shall she refrain from entering? What shall she take over? Here we find not only great differences of opinion, but a changing opinion upon once accepted points. For instance, the fact that nurses should not dispense material relief was once considered a fundamental principle of public health nursing.[13] Though still accepted by the majority as a wise tradition, certain leading thinkers feel that too great emphasis has been placed upon this prohibition and that nurses with a proper background of social understanding may under certain conditions well combine the distribution of material relief with the duties of public health nursing. Finer delimitations are also drawn, and the question is asked, what constitutes material relief and what constitutes medical relief? If medical supplies are furnished by a public health nursing organization, and under certain circumstances medicine, why stop there? Is not milk sometimes as necessary for recovery as medicine, and does not the inability to supply the one indicate about the same degree of poverty as the other? Why, therefore, in one case must application be made to another agency, and the situation in the other case be left in the hands of the nurse? Through the analysis of such fine gradations come changing points of view and remaking of public opinion. Years may pass before a solution of the problem of a wise apportionment of responsibility for health work among the various professional groups will be reached.

Nurses must be ready to hold out a welcoming and assisting hand to every allied worker, attempting nothing themselves that can be better and more wisely done by others, while at the same time the fact must be recognized that nothing but deterioration can result from such a relinquishment of duties and prerogatives as will take from the nursing group the more constructive elements of its work, leaving only routine duties that do nothing

[13] In the first edition of this book, published in 1916, the rule that nurses should not be distributors of material relief was placed among the fundamental principles of public health nursing. After consultation with several leading nurses and social workers the author has in the present edition omitted it from the list of fundamental principles, feeling that mention of it might better be made in a chapter dealing with more controversial subjects.

to incite creative power or stimulate enthusiasm. If, for example, the health educator should assume all responsibility for constructive health work in the schools, leaving to the nurse the mere routine of physical examination, a very short time would see the complete elimination from the school nursing field of all the more progressive women, leaving a residuum unfitted to carry on this important branch of public health nursing. This is equally true in other fields.

The worker exists for the work of course, not the work for the worker; but this does not necessarily imply haphazard development. In planning health work for the future wise forethought is required, for not merely must a cooperative plan be made that will prove locally workable, but one that will best carry forward the whole health movement. To accomplish this, responsibility must be so divided as to insure for each professional group a task sufficiently interesting and stimulating to attract to its ranks the finest type of worker.

PART II

PUBLIC HEALTH NURSING UNDER PRIVATE AUSPICES

Chapter 1

STARTING A PUBLIC HEALTH NURSING ORGANIZATION[1]

Though there is undoubtedly a tendency toward ultimate control of public health nursing by governmental bodies, private organizations still play an important rôle in the development of the movement, and in many places new work is best started as a private enterprise.

In its inauguration one point cannot be too strongly emphasized. Public health nursing is a community responsibility, and community participation in its maintenance must be secured from the beginning. If interest and support come only from without, an artificial situation is produced which rarely assures permanency. It is far better to sacrifice rapid development at an early stage in order to secure a foundation that will bear the test of future growth; for the withdrawal of a nursing service after the patients have learned to count upon it is a form of cruelty which few realize except those who are in direct touch with the sick.

In starting public health nursing in a new locality, the scope of the proposed enterprise should first receive consideration. It occasionally happens that circumstances have brought to the attention of those interested some one of the many special branches of the work, such as tuberculosis, child welfare, or mental hygiene, and an effort is made to start in the new field with a specialized nurse. This is a mistake, for the surest foundation on which to build a structure of public health nursing is the care of all the members of a community who require it, irrespective of class or type of disease. Unless provision is made for those already sick it is almost an anomaly for public health nursing to exist; for a nurse who instructs only and must leave

[1] The name "Public Health Nursing Organization" is here used to describe all organizations or associations engaged in any form of public health nursing work. Visiting nursing is included in the term.

a sick patient uncared for, is likely to preach her gospel of education and prevention to deaf ears.[2]

The amount of territory to be covered by the nursing service must be governed by considerations of local geography and local means of transportation. Generally speaking it is desirable to undertake at first only what can be well done by one nurse, though occasionally it may be found advantageous to start two or three nurses at the same time in order to gain the financial support of a larger geographical area. In rural districts an automobile is essential to any well-developed program, and the region to be covered can be considered accordingly.

The first step in establishing public health nursing in a new community is the enlistment of the interest of a small group of people who will hold a few informal meetings for the purpose of preliminary discussion of the subject. This group should endeavor to inform itself about public health nursing as done elsewhere, for it is a waste of energy to make avoidable mistakes. If more than one village or township is likely to be included in the scheme, proper representation should be arranged for from the first, for charter membership insures a more vital interest than can be secured at a later period. For the same reason the moral support of the various creeds and interests of the place should also be enlisted early.

In small towns public interest can perhaps best be aroused by an open meeting held in the town hall or some public school building. Usually a church, no matter how convenient, should be avoided, lest there be an appearance of sectarianism. At this open meeting a definite proposition may be placed before the townspeople, and free discussion of the project invited. A good public health nurse should if possible be present, who will in a short address make the work vivid to her hearers, and who will tell of the actual results obtained elsewhere. If a nurse cannot be secured, this must be done by someone else, for no abstract theory or list of dry statistics makes a sufficient appeal. While the necessity for nursing work among the very poor may be dwelt upon to some extent, the desirability of providing a nursing service for those of moderate means should receive due emphasis. Though care will be given free of charge to those

[2] This statement must be necessarily modified in regard to county work.

who need it, the stigma of "charity nursing" must not be allowed to attach itself to the work. Local statistics as to the infant death rate, or the number of deaths from tuberculosis, are telling, as are also local illustrations of the need of a public health nurse, provided always that such stories can be used with safety.

These simple methods, while sufficient in small communities, are naturally inadequate for the launching of public health nursing in a city of any size. The central idea, however, will be the same: to bring the aims and need of the work before as large a public as possible. In a city, this is best accomplished by means of a carefully arranged campaign of publicity in which the newspapers, the pulpits, local clubs, and personal correspondence and interviews all have a part. Even when the need of a large staff of nurses is obvious it is wise to start in a small way, possibly with a single nurse working in a circumscribed area. New districts may be opened as rapidly as is consistent with the building of firm foundations, and more complicated methods of administration gradually adopted as required. Mistakes, inevitable to a new work, may then be made under the shelter of comparative obscurity, and on a small, rather than on a large, scale. In other words the natural and safe law of growth from a small beginning will be followed and as the value of the nurse's services makes itself felt in the part of the city where she works, the desire for a like service will be aroused among neighbors and friends living outside of her district. Doctors will have a practical demonstration of a nurse's value that will make them wish to extend her usefulness to all their patients. Thus a healthful demand will be created which will greatly simplify the development of the work.

Nowadays, however, it is rare that in starting public health nursing in a city of any size virgin soil will be encountered. Even if no strong organization exists, one or more public health nurses are sure to be found in the field, caring for the sick in the vicinity of the churches or settlements that support them, or doing special work under the auspices of a tuberculosis league, child welfare society, or other specialized agency. Not infrequently where numbers of such independent nurses have been working for years, investigation reveals the fact that whole areas of the city and large classes of patients are unprovided

for, while on the other hand the duplication of work under these conditions has brought the entire system of special nurses into disfavor. Starting an organization in such a city is a difficult and delicate task, but amalgamation is quite possible and wherever accomplished has been found well worth the effort of adjustment. The ideal method is agreement on the part of those already employing nurses to place them on the staff of the new organization, there to work under the generalized system or, if the work is specialized, in the field designated by the supporting agency. A common plan of work is thus made possible, and common leadership insures uniformity of method. If this can be done, concessions may well be made to the special wishes of the affiliating bodies regarding details of administration, local headquarters, etc. Representation on the board and on all important committees will naturally be part of the arrangement. The selection of nurses must eventually rest in the hands of the nurse director, but if she is a wise woman she will do her best with all old nurses, and will realize that much time will be required, and many experimental efforts made, before a thoroughly satisfactory working basis can be evolved. Failing in such an arrangement as this—and agencies already employing nurses are usually reluctant to relinquish their own supervision to a new and untried organization—a central committee may be formed in whose hands are placed matters of general policies. Careful districting of the city will do much to provide an adequate service and prevent wasteful duplication of effort.

In all arrangements strength will be found to lie in a certain amount at least of centralization, but coercion is of little use, and it is wise to accept coordination or cooperation on whatever terms they may be offered, in the hope that growing confidence will increase the willingness to unite. The very desire to hold tightly the reins of power shows an interest the value of which must not be underrated.

Even if no affiliation at all can at first be accomplished, there is no cause for discouragement. The new organization may place upon its board of managers representatives of the other agencies already employing nurses, then by good work and a broad grasp of health problems address itself to the task of earning public confidence. When confidence is won amalgama-

tion may be more successfully sought, and the appeal will not be made to the uninformed, for the aims and methods of the public health nursing organization will be already familiar to the other agencies through their representation on the board.

In forming a public health nursing organization, one of the first questions to consider is that of membership. This may be conferred on all who give financial support or, as is customary with some hospitals, there may be a large enrolment in the corporation of members voted in by the board merely for their backing and moral support. In smaller places the latter method works well, although membership may be thus conferred on persons unable to contribute in money but whose contribution of time or interest is equivalent to, or far exceeds, the usual annual dues. All members have a vote at the annual meetings but are not usually convened except on these occasions.

It has sometimes been felt that the administration of a public health nursing organization should rest in the hands of women, because nursing is essentially a woman's work. Possibly this was true in the earlier days of the movement, when nursing the sick alone constituted the duty of a nurse. Now, when the work represents so much more than this, we can ill afford to do without the judgment and experience of both men and women. Their points of view are inevitably different, and both angles are valuable.

There are two ways of administering the affairs of an organization:—first through a small board of managers meeting frequently and regularly; and second by means of various committees of a larger board. Both methods have their advantages, but a broader responsibility is thrown on each member of the smaller board, and such responsibility develops latent powers.

In large cities a number of committees will eventually be found necessary, but in their early appointment care should be exercised to avoid such division of responsibility as will make the work as a whole difficult for the board to grasp. In the beginning it is more educative for the board itself to grapple with the various problems which later may be delegated to standing committees. If the organization starts with a number of committees, carefully prepared committee reports should be made at each monthly meeting of the board. Otherwise conti-

nuity of purpose will be lost. Many organizations have begun their work with a board of from ten to twenty members meeting monthly, and with one sub-committee, the nursing committee, which holds a weekly or bi-weekly meeting.

In most communities the question of finance is a burning one because the sum necessary for even a modest start seems large.

As the desirability and value of public health nursing has become more generally recognized, the earning capacity of the nurse has steadily increased. Local conditions differ, but a number of organizations estimate that about a third of their budget may be counted upon from receipts from patients and from the Metropolitan Life Insurance Company in payment for service to its industrial policy holders. The other two-thirds must be raised by other means, and it is the raising of this money which will constitute one of the most important duties of the new board or of its "ways and means" committee. On the best method of performing this duty it is impossible to make suggestions appropriate to all of the many and varied local situations. One general rule, however, may be laid down. The greater the education of the people to the need of the work, the greater the permanent financial strength.

An effort to secure a city or town subsidy seems the first logical step. Such subsidies were formerly feared, lest a string be tied to them which would hamper the freedom of the nurse in attacking abuses. Experience, however, has shown such fears to be groundless. Aside from a public subsidy, the simplest and most direct way of getting money is through the annual dues of a large membership. This support may in the main be counted upon because membership implies belief in the work done by the organization, and if the work is good this interest is sustained. In this connection the well-known axiom should be remembered: that it is safer to rely on one dollar from one hundred people than on one hundred dollars from one person, and every effort should be made to build up a large list of small contributors.

In the smaller communities fairs, bazaars, charity suppers and dances, whist parties, plays, etc., are familiar methods of money raising. These, however, are not always educative in

their results and reasons for giving other than interest in the work enter in; nor does the whole amount so donated find its way into the treasury, as expenses are usually deducted. There is danger, too, that those making small contributions at fairs and bazaars will consider that they have given sufficient support to the work and will feel no further responsibility. Tag days, though a more direct means of giving, require the expenditure of much time if they are to be educational and not irritating in their effect on the community. In industrial communities substantial support may be furnished by the factories, the proportion given by each being based on the number of hands employed. Memorial days may be endowed, or churches, small clubs or stores may make themselves annually responsible for a certain sum, this arrangement being made interesting to them by the publication in the local newspapers of their responsibility for the support of a nurse for perhaps a day, a week or a month.

A number of cities and some towns have successfully solved the problem of the support of their social and charitable agencies through the establishment of financial federations or community chests by means of which money for the support of all is raised at one time and apportioned by a committee to the various agencies represented.

Whatever sums may be raised in these ways, nothing should interfere with the principle of payment for the service by those who make use of it and who can afford it. This is usually arranged on a cost basis with a sliding scale to accommodate those of smaller income. A certain amount of free work will always be necessary because so slender a margin exists between independence and dependence with the majority of the poorer patients that even a short illness wipes it out altogether. Educational visits are unfortunately not at present popularly recognized as having a money value equal to those in which actual nursing care is given. This means a high percentage of free work in the educational field. Though this is more apparent under the specialized than under the generalized system, it is equally true in either case. As yet no satisfactory scheme for organized public health nursing on a paying basis has been devised in America, though interesting experiments based on the payment of a flat annual sum for family care are being tried.

No organization need be afraid to start work if it has the money in hand to meet the running expenses of the first six months, provided the nurse engaged, who may be leaving an assured position, understands the exact financial status. Reports of results already accomplished, and the fact that a nurse is actually at work, tend to bring in funds as no roseate promises of the future succeed in doing, and it is very seldom that a nurse once started is given up for financial reasons.

The nurse's own freedom from the weight of financial responsibility should be carefully guarded. She cannot do justice to her work if in addition to it any such burden is laid upon her. She may rightly be expected to present the work publicly when asked to do so, and can always at the same time make a statement of the financial situation. Such talks, however, are in the long run more effective if made with a view to educating the audience to an understanding of public health nursing than when given for purposes of solicitation.

So far we have dealt only with work that has been started in what may be called the legitimate way, namely, with a public health nursing organization as the administrative power. This, it is believed, should be the ultimate form of administration for a private agency unless unusual conditions exist; for public health nursing is a too highly specialized undertaking to allow of development to the fullest extent if carried on as a branch of some other activity. Occasionally, however, the fear of too hastily forming another organization in a community perhaps overstocked with associations and societies will make the starting of nursing work by some already existing agency seem wise. Also in small communities where leaders are few, it sometimes seems absurd to start a new enterprise with exactly the same people who already hold similar positions in a club or society which might possibly take up the work; as for instance, a civic club, congress of mothers, or other society with a broad program of activity.

However started, a special committee should be appointed whose sole responsibility will be the nursing work, and which will expect to give both time and study to the question of its development. This committee will be the best judge as to whether the work is strengthened or weakened by its connection

with the parent body, and when the time is ripe will be able to effect a separation without loss of continuity of method.

A town poor department should not inaugurate public health nursing, as in its very nature it would then be limited to the poor. For the same reason it is not considered best to place the work under the auspices of a charity organization, in spite of the very obvious convenience of such an arrangement. Though the more enlightened realize that the societies for organized charity do as much preventive as alleviative work, yet to the great body of the people they still stand as relief-giving agencies, and those able to pay for nursing care hesitate to employ nurses connected with them.

The question of the use of undergraduate nurses for public health work is discussed in other chapters.[3] Such nurses are students and unless proper educational opportunity and supervision can be afforded them they have no place in the public health field.

There is one situation that always presents difficulties. A single individual sometimes wishes to start public health nursing by giving the salary of a nurse on condition that there is to be no "red tape of organization." This is to be deprecated, except as a very temporary experiment. General public interest is not aroused, permanency and development are not assured, and the check resulting from more than one opinion is not placed upon methods of work. Also there is danger that the "lady bountiful" atmosphere may pervade the situation, an atmosphere that seriously interferes with healthy growth.

If any individual wishes to place a nurse in the field, two suggestions may be made: first, that only a portion of the salary be paid by that person, the first half at least being raised by the usual means; and second, that a committee be appointed, each member of which shares equally, in the responsibility for the undertaking. In this, as in all other methods of starting work, future opportunity and development should be borne constantly in mind.

The selection of the nurse is usually in the hands of the nursing committee, and too much cannot be said of the importance of starting with the right woman. No matter how perfect the

[3] Part I, Chapter 5, Section 1, also Part IV, Chapter 6.

organization, or how fine the board of managers, the nurse is, and must always be, the actual point of contact. Successful development will depend on her ability not only to do the work but to so see it, and so present it, as to both arouse and keep the intelligent interest of the board, and through it that of the whole community. No novice in public health nursing can do this. Large, well-organized agencies can place nurses without public health experience in subordinate positions to work under the supervision of thoroughly trained public health nurses, but the small town or rural district must have a nurse who has had, if not special training, at least experience under educative supervision; and inquiry of the most searching kind should be made as to her training, ability and personality. To a nurse of the right type definite leadership may safely be entrusted, for she will be quite capable of assuming it.

The nursing committee should be ready to assist the nurse to find living quarters wherever this is a matter of difficulty. Miss Elizabeth G. Fox, out of her wide experience in the rural and small town field, says, "Unsatisfactory living arrangements and the lack of congenial associates have caused many resignations that might have been avoided if the committee had given a little thought to the nurse's personal comfort."[4]

It is to be hoped that in thus considering in detail the many points connected with starting a public health nursing organization, no note of discouragement has been sounded. There is perhaps no other work in which grateful appreciation can be so counted on to keep up the spirits of the workers. A good board of managers and a good nurse have been known to form so strong a unit that in a few years they have radically changed health conditions in a community by no means noted for its progressiveness.

Three things may be urged upon those who think of starting public health nursing: *First,* a realization that important work lies before them, which they can in no wise do vicariously through their nurse but to which they must expect to give their own serious and personal attention. *Second,* an understanding that the work must be entered upon with minds hospitably in-

[4] Manual on the Organization of Public Health Nursing in Red Cross Chapters.

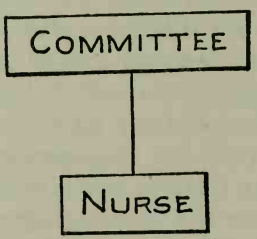
clined to new ideas, new methods, new developments, because so young a movement must not be crippled by limitation in its growth to any rigidity of preconceived ideas. *Third,* an appreciation of the fact that this is not an isolated group of people working alone for better health in a single locality, but is an important link in the great chain of the public health movement, and that the strength of the whole is its strength as well.

Chapter 2

PLAN OF ORGANIZATION

Organization was never intended to be an end in itself. As a means by which to provide satisfactory machinery for the accomplishment of a given purpose it is of vital importance. Faulty organization is at the bottom of far more trouble in public health nursing than is generally realized; and a habit of diagnosis applied to this subject is an excellent one to culti-

DIAGRAM "A"



vate. The principles of organization can best be studied in a good book on parliamentary law, but a brief description of these principles and the relations involved in them as applied to public health nursing may prove helpful in the present volume.

The simplest form of organization, and one that is common in the earliest stages of nursing development, is a single committee in which is vested responsibility for every part of the work. (Diagram A.)

Such a committee is occasionally self-appointed or is a subcommittee of some other body. More often it represents an organization or association by which it has been elected, and

from which it derives powers which are specifically stated in a constitution and by-laws.[1]

The second step is the appointment of the first sub-committee. This is usually the committee on nursing, and to this committee is delegated responsibility for such details as actually govern the nurses' work. At this point of development the original parent committee is apt to change its name and is known as the Board

DIAGRAM "B"

of Directors or Board of Managers. (Diagram B.) The nursing committee may or may not be made up entirely of board members as seems desirable. Because of the intimacy of its members with the actual work it is usually wise to have a sufficient representation of this committee on the board to influence opinion. In any case the chairman should be a member of the board.

It is at the next step, the appointment of other sub-committees, that confusion sometimes arises. The most complex structure will function smoothly, however, if a few elementary rules are observed, for all additional machinery is really merely an ex-

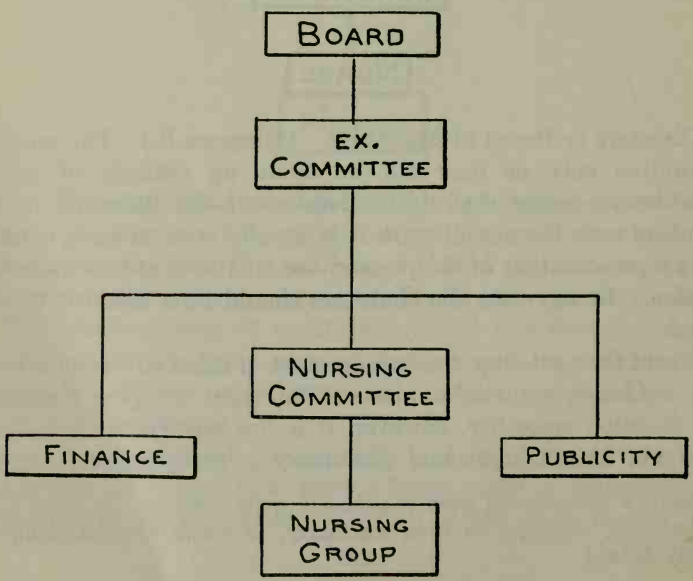
[1] Publicly administered work is naturally quite different. It forms part of the state, municipal or town machinery, to which its relationship is sharply defined.

pansion of the first committee. Subordinate committees are appointed by it simply to perform for it tasks which, because of their special nature or the time required, are necessarily delegated to a smaller body. Every sub-committee represents the parent committee which appoints it, and its powers are exactly those designated at its appointment, no greater and no less. Coordination of the whole organization is brought about by the representation on the next higher committee of each chairman of sub-committees. (Diagram C.)

An executive committee usually represents the board in all its functions, and other committees function through it.

A sub-committee should deal only with the committee to which it owes its appointment. This secures the clearing of all business through the board or executive committee. (Diagram D.) This is a rule not infrequently broken by the inexperienced, the chairman of one committee making, for convenience sake,

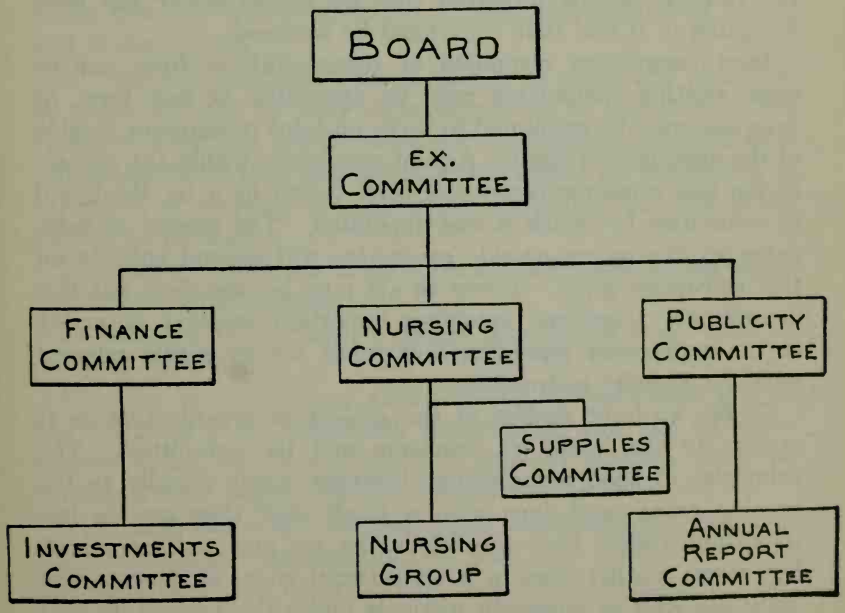
DIAGRAM "C"



unauthorized arrangements with the chairman of another. The board may of course authorize any such negotiations, and the powers delegated to the various committees may be extremely wide or very limited. On the whole it is unwise to allow matters affecting policy to receive final approval except from the Board or its representative, the executive committee.

In addition to the permanent or standing committees of which we have been speaking, the by-laws of most organizations permit the appointment of an unlimited number of temporary committees. These may be appointed by the board or by any other committee with such powers as it sees fit to delegate, provided the power so delegated does not exceed in any particular that of the appointing body. In the appointment of all temporary committees power and function should be clearly defined, and a time limit set to existence, though this may be implied by the nature of the service required. Temporary committees should not be

DIAGRAM "D"



allowed to drag out an inactive existence, but at the proper time should be formally dissolved.

An advisory committee, as its name implies, is a committee without power to act. It may be a permanent committee composed of interested and valuable citizens who are unable to give more active service, or it may be of a more specialized type, as for instance a medical advisory committee. Such a committee may be convened fairly frequently, or only in time of emergency, or it may never be convened at all, its members being consulted individually when necessary. In the latter case the name "committee" seems somewhat of a misnomer as it is in reality less of an actual committee than an official list of people willing and able to give advisory service on request. As a rule, however, an advisory committee is appointed to consider some special aspect of a situation from an expert point of view, and to report upon it, or, as is the case with the advisory nursing committees of many governmental bodies, to provide expert opinion on which those in authority may base their decisions. The indirect power of an advisory committee may be enormous, both in aiding legislative action and in leading public opinion, but it must not be forgotten that no actual power has been delegated to it and that none must be assumed.

Joint committees composed of representatives from one or more existing committees may be appointed at any time, or delegates may be appointed to serve on joint committees outside of the organization itself. A joint committee within the organization has whatever power has been vested in it by the board or committee by which it was appointed. The powers of delegates serving on an outside committee will depend entirely on the instruction given. Power to act may be complete, but this is unusual. Questions involving important matters of policy or the unexpected expenditure of funds are as a rule referred back for specific instructions.

So far we have spoken of the subject of organization as it applies to the board of managers and its committees. The principles of good organization, however, apply equally to the nursing group, and even with a small staff they are no less important. Most large nursing bodies are now well organized, but many smaller ones in a transitional stage of development cling too long to outgrown methods under the impression that

they are thereby retaining a spirit of friendliness and pleasant informality. As a matter of fact there is no more grace in slipshod methods of organization than there is godliness in ill-fitting clothes. If a certain amount of informality must be necessarily sacrificed to increasing growth, all of the earlier, friendly spirit can nevertheless be retained, for that spirit is engendered by personality, not by form or lack of form, in organization If staff work is done through committees, these should be properly appointed with due reference to the relation of each to each; and meetings, no matter how simply conducted, should conform to the commonly accepted rules of parliamentary law.

A director or superintendent of nurses stands in a strategic position in regard to her board and her staff, and through her hands should pass all the strands of the complicated skein of her organization's work. Otherwise tangles are sure to occur which will require infinite time to unravel. (Diagram E.) It is fairly safe to say that any plan which cannot be satisfactorily diagrammed will sooner or later prove a failure in actual administration. In the organization of her staff a director should study carefully the relationship of her subordinates to herself and to each other.

Nursing organizations vary so greatly in scope and plan that no universal rules for staff organization can be laid down. The appended diagrams are therefore not intended to represent ideal arrangements of staff but are intended rather as indications of a method of arriving at conclusions regarding the appropriate placing of personnel.

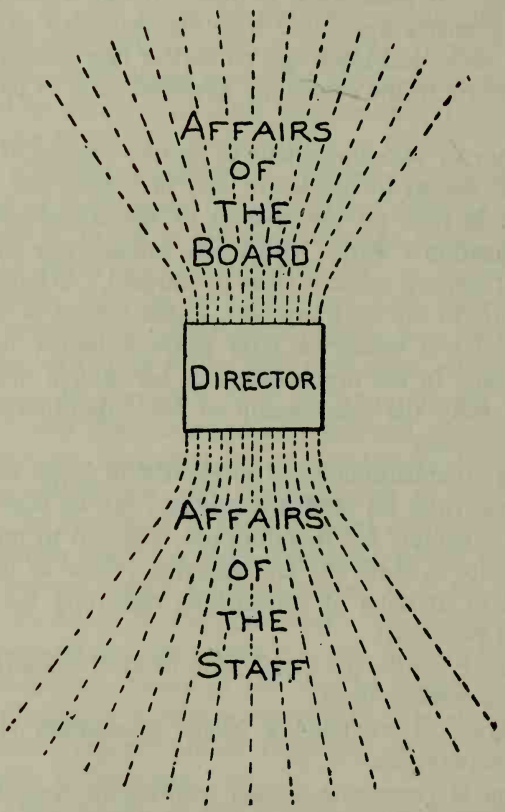
Diagram F shows the usual form of staff organization where generalized work is done.

In diagram G we have a larger generalized staff with its group of supervisors.

Diagram H represents a staff working in specialized groups, and Diagram I the same staff generalized, with the specialist experts acting as consultants and officially dealing with the individual staff nurses through the supervisors only.

Such diagrams might be multiplied indefinitely to show any number of logical combinations of staff, but enough has been said to suggest the diagrammatic method of working out the problem, and to emphasize the necessity for sound organization regardless of how simple or how complex the form may be.

DIAGRAM "E"



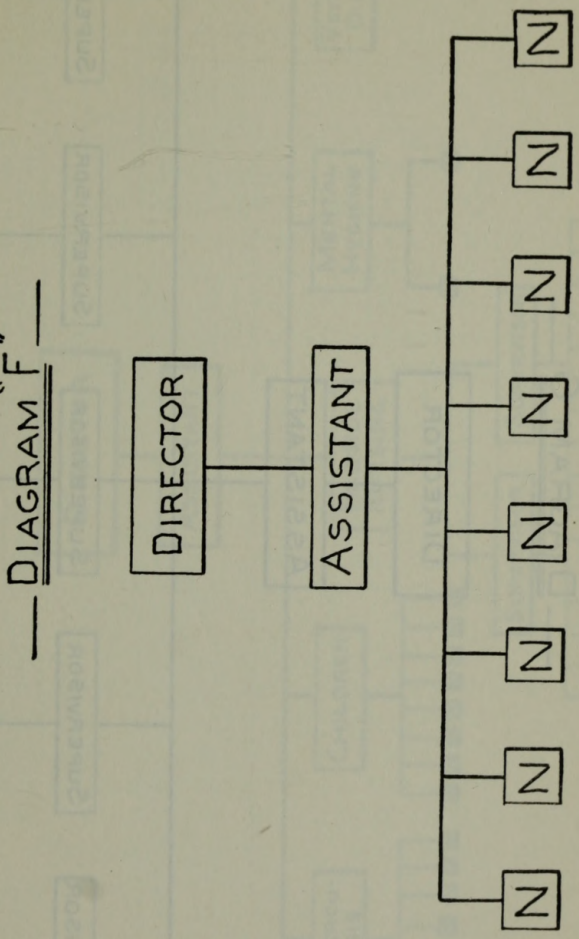


DIAGRAM "F"
DIRECTOR
ASSISTANT
Z
Z
Z
Z
Z
Z
Z

DIAGRAM "G"
DIRECTOR
ASSISTANT
SUPERVISOR
SUPERVISOR
SUPERVISOR
SUPERVISOR

DIAGRAM "H"

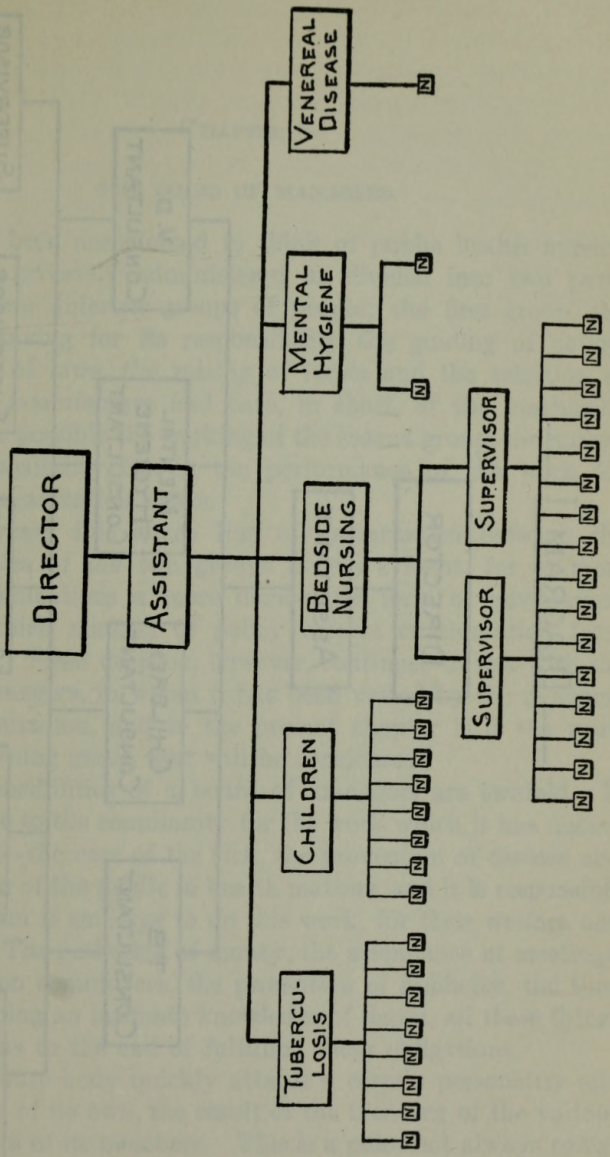
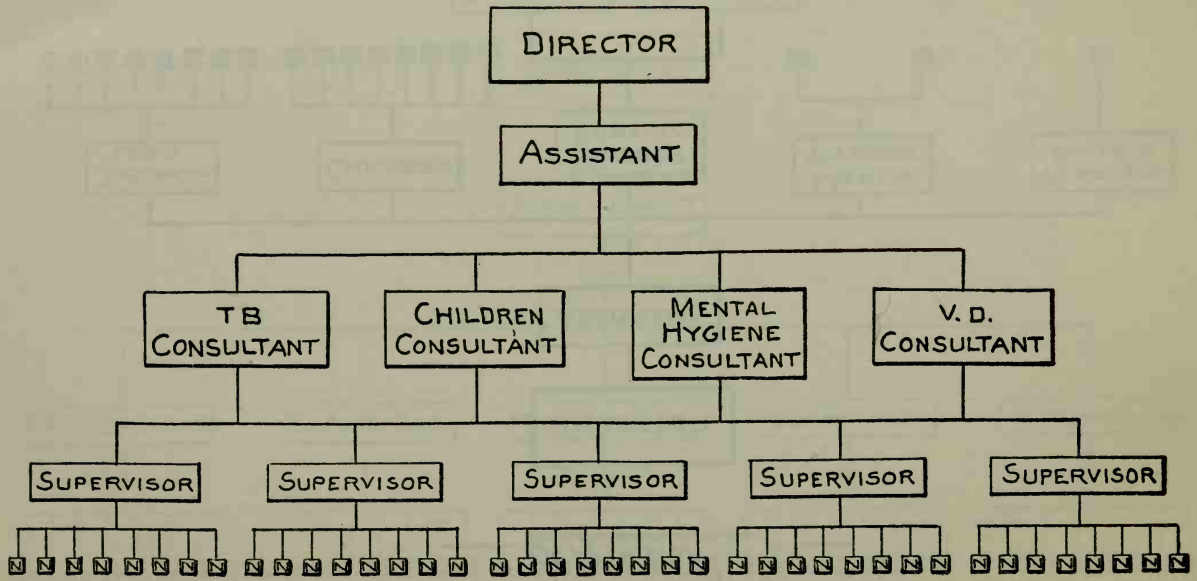

DIRECTOR
ASSISTANT
VENEREAL DISEASE
MENTAL HYGIENE
BEDSIDE NURSING
SUPERVISOR
SUPERVISOR
CHILDREN
TUBERCU-LOSIS

DIAGRAM "I"


DIRECTOR
ASSISTANT
TB CONSULTANT
CHILDREN CONSULTANT
MENTAL HYGIENE CONSULTANT
V. D. CONSULTANT
SUPERVISOR
SUPERVISOR
SUPERVISOR
SUPERVISOR
SUPERVISOR

Chapter 3

THE BOARD OF MANAGERS

We have been accustomed to think of public health nursing work when privately administered as divided into two parts served by two different groups of people: the first group, the managers, having for its responsibility the guiding of policy, the making of laws, the raising of funds and the selection of nurses; the manufacture and care, in short, of the machinery which makes possible the working of the second group, the nurses, whose responsibility lies in the performance of the work for which the organization exists.

Of late years this sharp line of demarcation between the responsibilities of the two groups is less evident, for in most modern organizations a more democratic form of government exists by which matters of policy receive consideration from both groups. Final decision, however, continues to rest with the board of managers, in whom it has been vested by the members of the organization, and in the present chapter it is the work of this governing group that will be considered.

The responsibilities of a board of managers are twofold. It is responsible to the community for the work which it has undertaken to do,—the care of the sick, the prevention of disease and the education of the public in health matters, and it is responsible to those whom it employs to do this work, for their welfare and happiness. The gathering of money, the attendance at meetings, the serving on committees, the promotion of publicity, the time spent in gaining an intimate knowledge of detail, all these things are but means to the end of fulfilling these obligations.

Any corporate body quickly attains a certain personality and individuality of its own, the result of the blending of the various characteristics of its members. This is a point not always recognized by the men and women composing such a body, who forget how potent for good or evil, for strength or weakness,

their own characters may be. United strength can move mountains, or perform the even more difficult task of creating a healthful community; but unity without strength, and strength without unity, are each equally powerless to produce results.

Many attributes go to the making of a well-balanced board. Very broadly speaking, there are three types of managers. There is the man or woman genuinely interested in the work, or ready to become so, who is willing to attend meetings regularly, who serves on committees and gives time to necessary detail work,—the manager, in other words, who carries the burden of the association on his shoulders. There is, also, the man or woman whose expert knowledge in some particular line is of great value, but who, though ready to be made use of on occasion, is unable regularly to attend meetings or to give time to ordinary committee work. There is also a third type, whose value is potential rather than actual,—namely, the young man or young girl whose youth and inexperience make their present contribution to the association small, but who later will work into the positions formerly held by their elders. Every board should have a few such young members, for without them, fine as may be the present status of any organization, no provision is being made for the future, and the kind of dependable interest most to be desired cannot be built up in a moment, but is of slow acquisition.

In the first selection of a board of managers, or the filling of vacancies, a certain balance ought, if possible, to be maintained. Beside the three individual types of members just mentioned, an effort should be made to secure representatives of the three religious groups, Protestant, Roman Catholic and Jewish, as also of any well-defined interest or section of the community. Neither men nor women should be allowed to predominate, nor should the members be selected from one small geographical area, or one, small or large, social set. The prestige attached to so-called social position cannot, and should not, be ignored; but public health work ought not to be carried on by any small clique in social life or confined to any social set, no matter how desirable each particular member may seem. On the whole it is wise to make some sacrifice of individual worth in order to secure a board which will be representative, in the broadest sense of that somewhat abused word.

As regards individual personality, neither the extremely radical nor the extremely conservative need be feared, for both these points of view will help the board to find that *via media* along which lie the best results. The same may be said of members who have bumps of criticism so well developed as to make them somewhat trying as co-workers. Such criticism is usually far more valuable if applied from within by a member of the board than when applied from without, hence it is sometimes wise to gather into the fold such an one, unless, indeed, dissension must be counted upon as a result.

It goes without saying that the power of leadership should be possessed by the president of the organization. In it is implied that knowledge of people which will enable him to make wise appointments, and with it should be combined the open mind which will hold wide the door to all new ideas. The routine of business will be much simplified if he is a good presiding officer, and if in addition he can be a man of professional, business or social prominence, so much the better, though often too high a price is paid for these latter advantages, and some one is selected who has no strong personal conviction of the necessity of the work and on whom the responsibilities of the office sit but lightly. If we have persistently alluded to the president in the masculine gender, it is rather because of the lack of a personal pronoun in the English language which can be used for men and women alike, than because of a belief that a man alone should hold the office. There are various advantages in a man president, but ability and interest, not sex, should be the standard for eligibility.

It is usual, but it is rather dangerous, to make the vice-presidencies purely honorary positions. Not a few organizations have been obliged to limp painfully through a year because sufficient provision has not been made for the unexpected incapacity of an able president.

The smooth running of any board of managers is more dependent upon the ability of the secretary than is often understood. The work of the president is greatly facilitated if he finds in the secretary a strong right hand on whom he can depend for all the details of the work. Usually a woman is desirable because of the amount of time she is willing and able to give;

but she must be a woman of tact and ability, for through her the organization will be presented to the outside world.

The treasurership is usually best held by a man, and one who has already won the confidence of the community, because such a name carries weight with contributors both large and small.

Perhaps the most important office next to that of president is the chairman of the nursing committee. This position should be held by a woman, and one who is prepared to give time and serious study to the work. She must possess wisdom, sympathy, initiative, and a practical mind; and she should also be endowed with a certain power of presentation, for on the reports and recommendations of her committee will largely depend the legislative action of the board.

As a rule the nursing committee represents the most progressive thought of the organization. This is natural because it is the committee in closest touch with the actual work of the nurses, and also because it is not subjected to the deadening drag of ultimate financial responsibility. The nursing committee needs much help in arriving at just conclusions, for vision and progressiveness untempered by reason seem to have a peculiar power of irritation when applied to a board. In placing emphasis and estimating relative values, the committee must avail itself of the stimulation and actual knowledge of work furnished by the nursing group, but it must at the same time take into equal consideration the knowledge of community resources presumedly possessed by the finance committee. One of the functions of the nursing committee is to act as a stimulant to the board, leading it constantly forward toward progressive action; but a committee which makes unreasonable financial demands, thus creating an atmosphere of antagonism between itself and the board to which it owes its existence, or between itself and other committees, weakens the whole cause. It is better, perhaps, to adopt a slower pace which all can follow.

A sub-committee on supplies is often appointed by the nursing committee which thus saves its own time for other matters. It is of course a recognized fact that it is poor economy to allow any of the nurses' highly paid time to be spent on such housekeeping details as supply-making or the type of shopping that can be equally well done by others.

As the nursing committee is usually the most progressive of all the committees, the finance or ways and means committee is apt to be the most conservative. This is as it should be, provided each is permitted to mitigate undesirable extremes in the other, and provided also that the finance committee bases its decisions on a real knowledge of the nursing situation. The chairman of the finance committee, like the treasurer, must possess the confidence of the community, and should unite an ability to grasp the broader aspects of the work with a balanced judgment that will prevent rash or unwise expenditure. A finance committee sometimes tends to become too powerful, and, because it holds the purse-strings, to develop into a court of last appeal. This it should never be. It is but a sub-committee of the board, and all important decisions should go to the full board in the form of recommendations for ratification.

Since publicity now plays so important a part not only in budget raising but in the educational propaganda usual with many organizations, a publicity committee is often found desirable. The policy of such a committee must of course be identical with that of the organization as a whole, and its expenditure carefully analyzed in the light of estimated results. The work of a publicity committee may assume large proportions, or it may amount to little more than supplying the local press with news notes. A suitable censorship of all publicity material is important, for not only must accuracy be assured but the ethics of nursing work be maintained.

In a town where there is no relief-giving agency to which a nurse may turn for assistance for her patients a committee on relief is necessary, which may apply itself to the study of approved methods of dealing with that most difficult of problems. It has been found, however, that it is better that such a committee should not be part of the nursing organization itself, because the nurse's position has been found stronger if the patients do not look to her or her organization for material assistance.

As the volume of public health nursing work has everywhere increased some of the larger cities have felt the necessity of some form of decentralization. This has been accomplished through the appointment of local committees which represent the various neighborhoods covered by the nurses, these com-

mittees having in turn due representation on the board. This effort to decentralize the work of the board but follows an earlier lead; for local stations, or branches used as nursing headquarters, have long been the rule in all large cities. The possibilities of local, or neighborhood, committees have not as yet received sufficient consideration. Their establishment certainly presents difficulties, and disorganization must be guarded against, but no form of democratic government is without its dangers, and it seems probable that in the future the neighborhood committee is likely to play an important part even in cities of moderate size.

It is a mooted question whether there is greater strength or greater weakness in relieving a board of the details of responsibility by the appointment of an executive committee. A board thus relieved is too apt to leave everything in the hands of its executive committee. On the one hand lie the advantage and disadvantage of concentrated power and responsibility; on the other, a wider dissemination of knowledge and information concerning the work, with a greater diffusion of responsibility which sometimes results in a lack of purpose.

Though the work of a nominating committee is quickly over, it is of the utmost importance to the welfare of the organization; and its appointment, by the president, the board or the corporation, should be a matter of careful consideration. The committee in presenting nominations will naturally weigh each candidate in the light of his individual attributes and also in the light of his special contribution to the balance of the board, and official group, as a whole.

There is one temptation of which the nominating committee and the president should alike beware—the kind-heartedness which is unwilling to remove an unsuitable person from a position of responsibility, though his inefficiency acts as a drag upon the progress of the whole work. It is one of the most painful of duties to depose such a person, particularly when he is giving of his best and is happy in the giving, but no important work should be allowed to continue to suffer on that account. The rare gift of leadership is not bestowed on every one, and many an unsuccessful chairman would make an excellent member of his own committee.

Every community will require a slightly different form of representation. The following list of the proposed personnel for a Red Cross nursing committee functioning in a county, is taken from the Red Cross Manual on the Organization of Public Health Nursing, and may prove suggestive:

The health officer.
A doctor (nominated by the Medical Society or the doctors as a whole).
A dentist (nominated by the Dental Society or the dentists as a whole).
A minister (nominated by the ministerial association or the clergy as a whole).
The superintendent of schools, or a member of the school board.
A county official (commissioner or supervisor).
A graduate Red Cross nurse (where there is a local committee on Red Cross nursing service).
A lawyer.
A newspaper man.
A representative of the Farm Bureau.
A representative of the Woman's Club.
A representative of the Tuberculosis League.
Representatives of some of the other active welfare groups such as Parent Teachers' Association, Rotary Club, Kiwanis Club and others.
Representatives of the R.F.D. families.
Representative of the Red Cross Branches.

The question of the membership of the nurse executive on the board of managers is one about which there is considerable difference of opinion. Some feel that her special training and intimate knowledge of the work give her vote a peculiar value which a board can ill afford to do without, and that on her own account she should not be deprived of the opportunity of exercising the suffrage in a cause in which she is so vitally interested. Others feel that as the salaried employee of the organization she should not be a member of the board but should rather be in the position of its valued representative, relieved of the personal responsibility of voting, but with the fullest powers of speech and discussion at all meetings. While the best organizations are agreed on the desirability of her presence at board and committee meetings, for purposes of both presentation and discussion, it should be possible for such meetings

to be held without her presence should the necessity for criticism of her work or suitability for her position arise. On the whole the consensus of opinion seems rather in favor of non-membership, though one at least of the largest and most important organizations in the country is based on the principle of nurse membership on all committees, including that of supreme control.

In the ideal board of managers each member contributes according to his ability, the president knowing where to lay his hand upon the kind of service needed at any moment. A wise president will study the personnel of his board, and in making appointments will take into consideration the educative value of committee work, as well as the capabilities of the members. Though the chairmanship of a committee should be given into capable hands, there may be placed to advantage on each committee some of the young or inexperienced members of the board, whose interest will in this way be aroused while they unconsciously learn many lessons which will later prove of value to the work. Too often there is no one to take the place of the tried veterans, who, owing to their ability, have been allowed to carry all the responsibility and to do all the work, and whose death or removal leaves the organization almost hopelessly crippled.

In order to guide any activity well, two things are necessary, a broad knowledge of the subject as a whole and an intimate knowledge of the special activity itself. A broad knowledge of the subject of public health nursing is obtained by reading, by visiting other organizations or by correspondence with them, by service on state or national committees and by attendance at conventions. How many board members are making use of these means of self-improvement? Knowledge of the individual organization is perhaps easier. It can usually be obtained by a regular attendance at meetings, provided a short time is first spent in acquiring a groundwork of information, and provided also that the meetings are made properly informative. How many boards make a point of giving any instruction or information to new members? Yet legislative privileges are granted at the very first meeting.

The problem of the monthly meeting is always a puzzling one to both president and nurse, for it is not easy to condense

into an hour's time all that is necessary in the way of information, stimulation and inspiration, together with the legislative action to which these naturally lead. Yet most boards grow restive if the allotted time is exceeded.

If the members of a board of managers realized how encouraging and stimulating intelligent questions are to the nurse, striving, often perhaps ineffectually, to put her subject before them, they would less often, with pleasantly receptive faces, receive her report without comment. The presentation of her work has not usually been part of a nurse's training, and it must be admitted that she sometimes fails to make it interesting or even informing. She will never improve, however, unless her failure is pointed out by questions that will show her the kind of information the board desires. If this is a particularly weak point the chairman of the nursing committee may be of assistance, not only by helping the nurse to arrange her notes to better advantage, but by herself asking at the meetings such questions as will elicit the desired information in the most interesting form.

It is not always the nurse, however, who fails to keep the board informed. How often in reply to the request of the president for the report of some special committee, are we told that the chairman has nothing to report that day. Why has he not? If it is legitimate that the committee has been inactive, let the chairman give the reason. Often the reasons for not acting are just as interesting as the reasons for acting, and the board should be kept informed of them. If any committee meeting has been held, the gist of proceedings should be reported.

Public health nursing is in itself interesting, and if the monthly meetings are not made so, something is wrong with the way in which they are conducted. When the nursing staff is large it will usually be represented at meetings by the director of the organization, but it is a pleasant custom to have other nurses occasionally present, either singly or in groups, to present their own special phases of the work. There is always a slightly different point of view, and in addition it is an advantage that the various nurses, as well as their problems, should become personally familiar to those who guide their work. These things may seem minor details, but large issues are made up of details,

and unintelligent legislative work is more often due to ignorance and carelessness, than to lack of ability to make wise decisions. The time has passed when a nurse represents merely a pair of capable hands and a little technical knowledge of sickness and health. In addition she is capable of considerable constructive thinking on her own account, and it is poor economy to forego the advantage of her brains.

This brings us to the second part of the responsibility of a board of managers, that toward the nurse or staff of nurses.

Plain common sense impels the owner of any fine piece of machinery to keep it in good order even at considerable expense. A public health nursing organization employs but one type of machinery, its nurses. Why is it that they are so often allowed to degenerate physically by the very men and women who would consider such neglect the acme of bad management in their own business or household affairs? Any organization which has to its discredit a record of unnecessarily impaired health for its workers is being poorly administered, no matter what it may have accomplished in the way of health for the community at large.

Three things make for the health of the public health nurse: a suitable salary that will enable her to live comfortably; a strict limitation of her hours of work, except in emergency; and, as far as possible, the provision that her work shall be done under happy conditions.

The standard of salaries is at present in too transitory a state to permit of definite statement.[1] Suffice it to say that a board should keep itself informed regarding the salaries paid elsewhere, and be unwilling to place itself on record as paying less than the most enlightened. If suitable salaries cannot be "afforded," then the work is being done under false pretences, and the financial burden is in reality placed on the shoulders of the workers, rather than where it belongs, on those of the community. The fact that many fine nurses are to be found who for love of the work are ready and willing to labor for less than they are capable of earning, is no justification for underpayment, and such sacrifice should not be permitted. In nursing, as in everything else, it is poor economy to buy what is merely cheap.

[1] See Part IV, Chapter 1.

Some nurses are not worth the lowest salaries paid them, but they are not the nurses it is worth while to employ.

The restriction of working hours is not an easy matter, but no woman stands continued overwork well, though with some the inevitable day of reckoning may be delayed by a strong constitution. It is not enough that the nurse be told that she must not work over eight hours a day. If it is the policy of the organization never to refuse calls, she simply cannot help it unless it is likewise the policy to add to the staff of nurses, either temporarily or permanently as the need arises. If this latter policy is not pursued then the former must be abandoned, and the board should honestly meet the difficulty and map out for the nurse some logical method of limitation which it will be within her power to pursue.

The question of meeting the constantly increasing demands of an inevitably developing work is a most difficult one, and is generally evaded by an expression of the vague hope that the nurse will somehow do her best. But it is not a problem for the nurse. It is a problem for the board, and should not be shirked by it.

The best results in administration seem to be gained by the exercise of great care in the selection of the nurse or director, and by then leaving her a very free hand regarding methods of work. If results are not satisfactory, it is far better to make a change than to try by restrictive measures to guide details.

The best women will never be retained unless they are allowed free scope for the development of their own, not other people's, powers; and it must be remembered that it is as impossible to gain results by arranging a groove, no matter how mathematically correct, down which the nurse must walk, as it would be to insist that she should wear for such exercise a certain size of shoe, selected because of its beauty or utility but without reference to the size of the wearer's foot.

Though the nurse or director must work out her own salvation as to methods and administration, it is not meant that she should do so alone or unaided. She will need every particle of backing that the strongest board can give.

For those who have had an opportunity to study the inner workings of various visiting nurse associations, it is interesting

to attempt an analysis of the causes of failure or success. Invariably it is found that these causes exist within the organization itself, no outside influences or obstacles ever seeming capable of blocking progress if managers and nurses have the right point of view. On the other hand the most favorable outside environment does not seem to have any effect in producing good results if managers and nurses are in themselves weak, or fail to pull together.

It falls to the lot of most directors of nurses to do more or less visiting among sister organizations, either in the capacity of "speaker" at annual meetings, or as diagnostician of special situations. The experiences of one such director in three different towns may serve as helpful illustrations of certain causes of failure. In all of them the highest motives actuated the managers, and in all three a change of policy turned failure, or partial failure, into success within a comparatively short time.

The first experience was with an organization that was apparently being carried along by the enthusiasm and effort of a single individual, the president, who complained somewhat bitterly of the utter lack of interest of her board of managers, and of their unwillingness to bestir themselves to help her in the difficult task of raising money.

The director was asked to speak at the annual meeting, and went with some curiosity as to the cause of this lack of cooperation.

The meeting was well attended, and there apparently seemed no lack of sympathy and intelligence among the audience, but after it, the worried president again spoke of her difficulty in interesting her board in the work, some of them even going so far as to advocate giving it all up on the ground that the effort to continue an organization was hardly worth while. As the statistics of the year read by the secretary showed a more than sufficient number of cases to prove the real necessity of a nursing service, this seemed most unfortunate. Having missed any report from the nurse, and thinking that a talk with her might throw light upon the difficulty, the visitor asked to be introduced, but was told that she was not at the meeting, apparently because no one had thought to tell her that such a meeting was to take place.

In further conversation with the managers it transpired that most of them did not know the nurse by sight, and that, never having heard her describe her work, their sympathies and interests were only partially awakened.

How could they be expected to do the drudgery of money raising without the incentive of a conviction of the necessity of the task, and how could they feel this conviction without a personal knowledge of the nurse's doings? Furthermore, without either this conviction or this knowledge, how could they be expected to guide her work intelligently?

In this town the mere regular attendance of a bright progressive nurse at the monthly meetings of the board worked wonders in no time, for the report of her work, and the simple stories told by her, brought home to the managers as no statistics had been able to do the real meaning of what the nurse meant to the people.

Another organization applied for help because of the difficulty of keeping a nurse. Four nurses described by the managers as "well-recommended" had come, had done good work, and after a few months, apparently without reason, had decided to go elsewhere. The managers were greatly discouraged, because they were intensely interested and felt that they were paying a good salary and honestly meant to deal fairly by their nurses in every way.

At first the visiting director was puzzled, but began to have an inkling of the truth when in describing the situation, manager after manager used the expression, "We never allowed Miss Blank to do this or that." A talk with the last Miss Blank revealed the fact that these excellent and executive women in their zeal for detail had allowed to their nurses less initiative than they would have been obliged to permit the cooks in their kitchens. They had in each of the four instances apparently secured well-trained and experienced public health nurses, who could not work happily because they were treated like children.

The final illustration is of a manufacturing city of some fifty thousand inhabitants which had been among the first to start a visiting nurse association. After many years of activity this association still employed but one nurse, who seemed not overbusy in spite of the steady growth of the city.

It naturally seemed that the trouble was probably with the nurse in failing to bring the needs of the people to her board. While this was in a measure the case, it was not by any means wholly the nurse's fault. During her first year of work she had frequently reported that she found it difficult to meet the demands made upon her in even a ten-hour day. The response had always been that her predecessors had found no such trouble, and that with a little management she would undoubtedly be able to get through. On inquiry it became clear that the older members of the board of managers, those who for years had controlled the policy of the association, giving to it a beautiful and unselfish devotion, were wholly uninformed as to the progress and development of public health nursing elsewhere.

They had taken it for granted that each city had one nurse and no more, and were greatly shocked at what they felt must be the unhealthy condition of the cities described by the visitor as making use of a large staff. Some vigorous reading on the subject of public health nursing, together with visits to neighboring organizations, produced a change of policy, and in an incredibly short time this city had a dozen nurses at work under a director whose continued plea for more nurses was met by a board of managers as eager as she herself to supply the need.

Where things have gone badly, the trouble has often lain with a nurse or nurses who have been narrow-minded, or insufficiently trained for public health work, but this in no way exonerates the board of managers, for in the final analysis it is the board which is responsible. It should so inform itself of work done elsewhere that it will have a standard of excellence to apply to its own situation and it should so know the nurses and director, and their powers and limitations, as to be able to help them to their own best development or, failing this, to make such changes as may seem best until true efficiency is secured.

In the long run boards of managers usually attain for their community what they most want. Therefore it behooves them to think well and to make up their minds what it is that they do want. In the modern rush and hurry of life, and the rightfully insistent demand for efficiency, it is well to remember that there are other things as important to public health nursing as effi-

ciency. Gentleness, kindliness, sympathy, "love" in the Biblical sense, are quite as important attributes in the public health nurse as ability; and if this fact is recognized by everyone a correspondingly healthy atmosphere will pervade the work.

Few boards and few nurses fail in motives of high idealism for their organizations. What is most often wanting is not a common purpose but common ideas for the achievement of that purpose. Many compromises are necessary on both sides before conclusions are reached, but unity of thought is often born of compromise, and there are few points of view that are not broadened by the necessity for modification.

PART III

PUBLIC HEALTH NURSING UNDER PUBLIC AUSPICES

Chapter 1

STATE

A long step forward in the recognition of public health nursing was taken when the first state public health nursing laws were passed. These laws have been very divergent. Most of them are permissive, but in two or three of the states they are mandatory, requiring the appointment of nurses or the establishment of a bureau or department of public health nursing.

The task of tracing the historical development of public health nursing legislation is difficult and unproductive, because so many early laws have been repealed or altered by later ones.

Of the public health nursing laws now in force, the oldest are those of Massachusetts and Pennsylvania, both dating from 1911. Every year since then except 1912 has seen the enactment of state legislation, but though laws pertaining to public health nursing are in force in a majority of the states (33 states in 1923), in only two states is provision expressly made for a state bureau or division of public health nursing.[1]

The laws vary in every way:—as to the territory to be covered, whether state, county, town, township, village or borough; as to the type of work to be done, whether general public health nursing, school nursing, tuberculosis nursing, mental nursing, child welfare, midwife inspection or general social work; as to the required qualifications of the nurses; and as to the form of supervision provided. The nurses' work is variously directed:—by state, county, city, town and village health authorities; by county commissioners; by educational authorities; and by private visiting nurse organizations receiving aid from official sources.[2] In some states the form of direction is not specifically covered by statute. Time will undoubtedly show what is the

[1] "A Review of State Laws on Public Health Nursing," James A. Tobey, Washington representative, National Health Council.

[2] "A Review of State Laws on Public Health Nursing," James A. Tobey, Washington representative, National Health Council.

form of legislation best fitted to the purpose. Meanwhile any legislation at all is undoubtedly a step in advance.

Financial methods also have varied greatly. In some instances state supervisors, though responsible to state authorities, are supported wholly or in part by other agencies. The Red Cross and the National Tuberculosis Association, for example, have become individually or jointly responsible for salaries in a number of states, though the arrangement has always been tentative, looking toward the day when the state itself will feel the necessity of financing its own nursing work.

Although there is a decided sentiment in favor of a state bureau or division of public health nursing under the state department of health in charge of a chief nurse, under whom all state nursing work should function, this sentiment is not quite universal. There are those who believe that a separate nursing division would only confuse administration. Dr. Levy, for instance, says, "I believe that the state department of health should be organized according to function and not according to the instruments that may be used to serve these functions."[3]

State nursing work is perhaps as yet too new to warrant a definite decision on this point, but in municipalities the establishment of a division or bureau of public health nursing has proved a most satisfactory arrangement, in that it provides a chief executive belonging to the same professional group as the nurses themselves, and therefore an acceptable and satisfactory leader. Such a chief nurse should have a budget of her own, with the same power to develop her department as have other heads, and an equally free hand in the selection of her subordinates. It goes without saying that she should be a worthy representative of her profession in the state, and possess such knowledge of public health nursing as to command respect and inspire confidence. The salary should be commensurate with such demands, and should compare favorably with those paid to other departmental heads.

State laws and methods so differ that it is impossible to write definitely of details. Miss Stack, of the Connecticut State

[3] Dr. J. H. Levy, *Public Health Nurse,* October, 1920, quoted from correspondence of April 17, 1920.

Department, has defined the functions of a state department of public health nursing from one point of view. "Such a department," she says, "standardizes, advises and assists, without direction or regulation."[4] On that basis such a department would require but a small staff of highly trained consultants or possibly a single nurse supplied with adequate clerical assistance.[5] From the far West, however, we get a quite different point of view expressed by Miss Allen of Oregon, who describes the purposes of a bureau of public health nursing as threefold: to educate, to organize and to standardize. "Having," she says, "initiated in a given community enough health educational work to insure at least a nucleus of interest and desire, the next step in the program is organization. This should become the immediate goal of the state bureau of public health nursing."[6] Miss Allen advocates short county demonstrations, and describes a plan of procedure to be followed by a state bureau in order to secure the organization of a county public health nursing association. She says, "When public health nursing is being started in a county for the first time, the field supervisor of the state bureau accompanies the new nurse to her county. She introduces her to the physicians, county commissioners, school officials, and others who have shown an active

[4] "What a Nurse Owes to Her Position," Margaret K. Stack, Director, Bureau of Child Hygiene and Public Health Nursing, State Department of Health, Connecticut.

[5] The Connecticut Bureau of Public Health Nursing (organized as a Bureau in 1923) does not act as an administrative body but offers an advisory and supervisory service on request. The work of the Bureau is classified under six headings.

1. Development of public health nursing associations.
2. An advisory, supervisory and consulting service furnished on request.
3. Placement of nurses and maintenance of standards.
4. Records and reports.
5. Tabulation of information regarding the public health nursing associations in the state, and distribution of leaflets and sample forms for their use.
6. Collection of exhibit material.

[6] "What Constitutes a State Program of Public Health Nursing," Jane C. Allen, paper read before session of State and Municipal Nursing, annual convention of the National Organization for Public Health Nursing, Seattle, May, 1922.

interest. She helps her plan a regular schedule of visits over the county, designating the geographical centers as community centers. She makes with her the first round of these centers."[7] Miss Allen goes on to say that when the time is ripe for permanent county organization the state bureau of public health nursing supplies a standard form of constitution and by-laws, and through correspondence, bulletins and the regular field visits of supervising nurses, continues a certain direct responsibility for the work.

In these two conceptions of the functions of a state department of public health nursing we have the extremes of thoughtful, well-considered opinion. Between the two points of view there are perhaps as many shades of opinion as there are geographical miles between Connecticut and Oregon. The State of New York has a division of public health nursing which provides all nursing service for the state department of health, nurses being detailed from it to the work of other divisions, while a large group of supervising nurses is employed who work throughout the state, a certain number assisting the sanitary supervisors in the general work of their districts, and the rest engaged in other lines of work.

Whatever the plan, whether administrative or consultive, the end in view is the same, namely, to secure, eventually, throughout the state an adequate and well-standardized public health nursing service. To what extent such nursing shall be centrally administered from the state division of nursing, to what extent it shall be decentralized through the sanitary district or county unit plan although still in a measure controlled by state authority, and to what extent local initiative acting through private organization shall be employed, with the state merely serving as consultant, must depend on so many other factors that we may well hold opinion in abeyance until longer experience in the various states shall have provided a better basis for decision.

Whether the work of a state nurse be consultive or administrative, she must be thoroughly acquainted with nursing conditions throughout her state, and this information should be so tabulated and kept up to date as to be readily available for

[7] *Ibid.*

study and comparison. This will entail a budget sufficiently large to cover an adequate clerical staff, and a sufficient allowance for traveling expenses, the purchase of necessary equipments, etc. There should also be an allowance for the printing and distribution of health literature, and, if the staff is large, for the publication of some form of nursing bulletin, unless health literature and nursing bulletins are provided by some other department of the board of health. Spot maps if well prepared will be found helpful.

In studying the nursing situation in a state, two factors must be taken into account,—the geographical distribution of nurses, and the functions performed by them. There may be a fairly satisfactory number of nurses per capita, but with an overwhelming proportion huddled in the cities or in one particular part of the state; or the nurses may be geographically well distributed, but some important branches of public health nursing may be left wholly untouched.

Every state has its own peculiar problems, and with these a state nurse must be thoroughly familiar. In some states it will be the isolation of the farming communities; in others overcrowding due to industrial conditions; in still others, special diseases or conditions must be contended with, such as malaria, hook worm, or the migrating tuberculous patients who flock in such numbers to certain localities.

All the information possessed by a state nurse will be needed. If her function is that of consultant she may be assured of one thing, that if she has something worth having to give and something that people want they will surely come, and come again to get it. Health officers, members of private organizations, doctors, nurses, other department heads, interested individuals, any or all of these who succeed in getting the help and advice they need, will return for more, and will spread abroad the news that such help is available. If, however, a state department of health expects to provide a nursing service to which others will look for leadership and to which the standardization of public health nursing of the state may be safely entrusted, it should realize that it must secure for these purposes the finest type of nurse procurable. Private organizations in most states are themselves well organized, having as directors women of

experience and training, and they are not likely to seek nursing advice from a state bureau less well equipped. In other words, if the function of leadership is to be assumed by a state bureau or department of public health nursing, true leadership must be provided by those representing it.

Perhaps in no way can a consultant state nurse more effectually further the progress of public health nursing in her state than through the establishment of a standard for the type of nurse to be employed. This cannot, of course, be done by compulsion, and this fact must be made quite plain. It has been found, however, that the employment of unqualified women has been greatly reduced where a state public health nursing bureau is prepared to make definite recommendations on this point, giving at the same time adequate reasons therefor. In many states the standard adopted by the National Organization for Public Health Nursing will be found applicable, but this must be modified by local considerations, for it is useless to make recommendations that cannot be carried out.

Carefully prepared nursing bulletins, issued periodically and sent to every public health nursing agency in the state, tend to extend the influence of a public health nursing bureau beyond what would be possible through personal contact alone, and every state nurse should cultivate the art of writing and of public speaking, for on her powers of presentation through such mediums will depend much of her success.

Where a bureau or division of public health nursing is an administrative body and a large staff of nurses is maintained, the work undertaken may cover almost any field. The most usual point of entry is that of child hygiene, largely owing to the acceptance of the Sheppard-Towner Act by a majority of the states. Though the public health field may be entered through any avenue, a good state program of public health work does not admit of much limitation. In states having well-developed sanitary districts or county health units it is usual to decentralize the nursing work and place nurses in each district or county with field supervisors to direct and guide their activities. To these general supervising nurses may be added specialists who act as consultants in special fields.

Owing to the difficulty of securing nurses properly equipped

for the responsibilities of county work, it is usually necessary to give considerable time to their supplementary education through supervisory visits, conference meetings, summer institutes, correspondence courses and the medium of special literature and monthly bulletins; and the supervisors in their turn should be given every opportunity to widen their range of vision through attendance upon national conferences and conventions.

A list of the activities of the division of public health nursing in one state will give some idea of their wide scope, and will make plain the demands made upon the nursing group and the variety of responsibilities assumed by the staff. In the particular state described the division of public health nursing provides all nursing service, nurses being detailed from it to the work of other divisions. The following is a description of work undertaken in 1922. Establishment of prenatal clinics and assistance to physicians in conducting them; teaching in extension courses; supervision of midwives; instruction of nurses in maternity hygiene; supervision of child welfare stations and demonstrative and consultive work in child welfare organization; inspection of maternity hospitals and boarding homes and instruction of nurses in the technique of midwife inspection; assistance in conducting tuberculosis clinics and assistance to tuberculosis nurses in standardizing their work and record systems; instruction in schools in the control of communicable diseases, and investigation of various communicable diseases, including ophthalmia neonatorium and epidemic jaundice, with visitation of public institutions for the purpose of preventing communicable disease; inspection of venereal disease clinics and instruction to nurses in venereal disease work; attendance at county fairs and exhibits, and addresses at farm bureaus, mothers' clubs, nurses' organizations, schools and other agencies; organization of after-care at infantile paralysis clinics; assistance to physicians in the physical examination of department employes; attendance at meetings of boards of health, boards of supervisors and lay organizations; correspondence with local public health nurses throughout the state of whom a roster (over 1,100) is kept as nearly up to date as possible; and special work on two Indian reservations, including home visitation for bedside care and instruction, investigation and demonstration, class instruction

to mothers in home care of the sick, and first aid, as well as talks on personal hygiene to Indian school children, organization of tuberculosis clinics and inspection of midwives.[8]

All this requires trained and seasoned workers, or at least women capable of acquiring a high degree of training. Yet in state work, as in municipal work, a chief nurse executive often labors under two difficulties which are not met in privately administered organizations, namely: the appointment of her staff through civil service, and life tenure. The civil service system has unquestionably helped to remedy some of the evils of political domination, but where rigidly administered too little account is taken of personality and other qualities difficult to judge by means of examinations, but which nevertheless count so tremendously in the success of public health nursing. It is usually possible to refuse final acceptance of a nurse after six months' trial, but in many states the first nurse on the list must be given an opportunity to make such trial, no matter how obviously unpromising she may be. The loss of time and the consequent poor work resulting from such a method are too apparent to require comment. At the end of six months the temptation to abide by a known evil rather than to repeat the weary process often induces the acceptance of an undesirable woman, and then, if the position is for life, nothing short of serious misdemeanor permits of displacement. Certainly the old political game of stage coach, played at every change of administration merely for the sake of playing it, was bad enough; but to a chief nurse, trying to do important work, it was preferable to being burdened by a staff of irremovable incompetents.

The system of civil service appointment, however, need not necessarily work badly. If reasonably administered it merely means that every nurse employed shall have passed a civil service examination. If selection is then made on competent nomination, or by a committee familiar with the requirements of public health nursing, the system works well.

It is sometimes claimed for life tenure that it tends to prevent migration of experienced nurses, and that in consequence work is stabilized. The disadvantages of the system, however, in the

[8] Division of Public Health Nursing, Health News, February, 1923, *Bulletin of New York Department of Health.*

present fluid state of public health nursing development, would seem to considerably outweigh the advantages, for women who are fitted for a piece of work at one stage of its growth are not always best fitted to administer it at a later period; and the demands of public health nursing require a mind open to new ideas and a body capable of the continued strain of constructive effort, attributes generally associated with youth or early middle age.[9]

In the past, state and municipal boards of health seem to have been looked upon somewhat in the light of police forces, established to catch and bring to justice offenders against the law. Unfortunately this point of view seems still to linger in the minds of the public in some localities; and where this is so, a state nurse has a great deal to overcome before she can be looked upon as the trusted friend and counselor that she is prepared to be. She must earn her right to that relationship by the exercise of wisdom, patience, sympathy and the habit of finding and respecting the good motive which underlies so much faulty work.

It has sometimes been said that it is not necessary to work as hard in government as in private positions, because a government body is so impersonal that there is little pleasure in serving it and a minimum of effort is as satisfactory as a maximum. Were such an attitude of mind permitted to infect the increasingly large group of nurses who are becoming "public servants," there would indeed be a hopeless outlook for public health nursing, but the number of fine, strong, hard-working women, entering the field with high enthusiasm, and giving to their governmental work the same devotion that they formerly gave to private organizations, refutes any such statement. Their efforts may receive the due reward of appreciation from the divisions and departments which they serve, but if this should not be the case (and from what private or public agency is appreciation assured?) they will still have the satisfaction of a great opportunity, for they go forth to prove to the citizens of states, counties and municipalities that public health nursing is something so valuable that it is worth while being taxed for its maintenance.

[9] For further discussion of the Civil Service System, see Part III, Chapter 3.

Chapter 2

COUNTY

For purposes of convenience this chapter has been placed among those dealing with publicly administered work. While county nursing is not universally administered by public agencies, yet the tendency toward such ultimate responsibility is evident.[1] Many excellent pieces of county work now being done by private agencies are quite frankly felt by those responsible for them to be essentially demonstrative, anticipatory of the time when the county itself will become responsible for them.

Public health nursing both in England and America began in cities and towns. In England the idea gained an early welcome also in the country districts, but in America much less readily. This was doubtless due in part to the fact that in America there was no strongly centralized administrative organization like the Queen Victoria's Jubilee Institute, but there have also been other practical reasons. Rural settlements in America are widely scattered over vast areas of country, there are numberless isolated farms and ranches situated many miles from the nearest habitation or railway, the winter climate of a large part of the country renders transportation difficult or impossible, and at all times of the year the majority of American roads compare unfavorably with the English. Conditions of land tenure in England have also undoubtedly had their effect, for from time immemorial the English landlord or country squire has felt a personal responsibility for those living on his estate and this paternalistic attitude has no analogy in American rural

[1] "The 957 organizations listed in the 1922 tally (of county organizations) were distributed as follows: County government agencies, 96; county public health or public health nursing organizations, 117; tuberculosis societies, 119; Red Cross chapters and branches, and organizations affiliated with the Red Cross, 583; other voluntary organizations, 42." Article by Mary Augusta Clark, Consulting Statistician, National Health Council, *Red Cross Courier,* September 1, 1923.

life. Moreover, the English "parish" represents a natural unit of small size, which, singly or in groups, is excellently adapted for autonomous action. But while it is not difficult to see why rural nursing has been an easier proposition in England than in America, it must be admitted that several other countries, as for instance Canada, Australia, New Zealand, Norway and Sweden, have been before us in recognizing the necessity of rural service and in overcoming the difficulties of its introduction.

Though for years there was no widespread effort to secure public health nursing for rural America, there were nevertheless many isolated attempts to deal with the situation. Progressive villages occasionally secured a nurse for themselves and a few city organizations enlarged their boundaries and allowed their nurses to go out into the surrounding country. There were one or two successful experiments inaugurated by individual nurses, such as the Westchester County (N. Y.) work of Ellen M. Wood, and Lydia Holman's well-known work in the Kentucky mountains. For years, however, these efforts seemed only to emphasize the difficulties and expense of rural nursing, and for the most part it was considered either unnecessary on account of the supposed health and well-being of the country dweller, or impossible for practical or financial reasons.

With the inauguration of the Rural Nursing Service of the American Red Cross in 1912 came a wider recognition of the possibilities of the rural and small town field. The efforts of the Federal Children's Bureau, and the information assembled by the National Organization for Public Health Nursing, the National Tuberculosis Association, the Society for the Prevention of Infant Mortality and other national health organizations brought to light the actual conditions of rural health. It only required the draft figures showing the number of rejections due to physical disabilities to make clear the fact that the state of our national health left much to be desired, and that country boys made no better showing in the number of rejections than city boys, while the experience of army medical officers showed them less resistant to contagious disease than the city bred. To the surprise of most people, the physical examination of rural school children has shown a greater degree of physical defect than among city children, and in many a rural community the

infant death rate has been found higher than that of the cities. There is no reason why this state of things should be considered inevitable, for it does not exist in all countries, notably in New Zealand, which is an agricultural country, where the infant death rate is the lowest in the world.[2]

The way out of the difficulty would seem to lie in securing for the rural districts, so far as is necessary, the same health measures that have been successful in the cities, namely, suitable sanitary arrangements, adequate medical and nursing service in times of illness, opportunities for early diagnosis and treatment of disease, health education and physical examination of school children, skilled oversight of babies, clean milk, and, perhaps above all, a type of health instruction that will make all these things desired, a factor that is so surely changing the attitude toward health of city dwellers. This proposition may perhaps sound simple to those accustomed only to city work, but to obtain anything even approaching adequacy in these various lines for rural communities is extraordinarily difficult. The question of finance alone is baffling to a degree, for the cost of a good system of public health is very high for the average country community. The solution may lie, as in the educational field, in state subsidy. This would mean no new policy in health work, for Federal and state subsidy have already been applied to campaigns for the elimination of such diseases as hook worm and malaria, and the Sheppard-Towner Act makes provision for Federal subsidy for work with children. Nor is the financial problem the only one. The mere question of distance complicates all arrangements, though Mr. Ford has done his best to make cheap transportation possible.

One of the first questions in attacking the rural health problem has been the selection of a unit for work, and the township, the county, and a purely arbitrary geographical district have all been considered as possible units. Though various methods exist in different states, on the whole it is felt that because the county is the unit of civil government in the great majority of states, it also furnishes the best unit for health work. The selection of a county, however, for purposes of health admin-

[2] "Better Health for Rural Communities," George E. Vincent, *Proceedings Second Annual National Country Life Conference.*

istration does not preclude other methods. On this subject Dr. W. S. Rankin says: "The county is the logical unit of health administration. There is no conflict between the district and the county plan of administration. You may go from the district to the county health officer, or you may begin in the county and work up to a supervising officer of a number of counties that is a district officer."[3]

A nurse undertaking county work will naturally first acquaint herself with the health organization of which she is a part. If she is fortunate enough to find herself in a state which has a bureau or division of public health nursing, she will of course know her exact relation to it and to the state board of health. Her first interest will therefore be her county health machinery and its personnel. Here she may find a great diversity of arrangement. She may find herself part of a fully organized county health unit, with a county public health board, a county health department and a full time health officer, or she may find herself in a county wholly unorganized for any health work, without a health officer or with one who is a busy farmer or shop keeper and who gives only a nominal attention to health matters. If she is a Red Cross nurse she will have her Red Cross relationship to division head, and to county and local chapter committees. If she is not, she may find herself in a more or less isolated position. Her county itself may also present the greatest variety of conditions. It may be of small geographical area with railroad facilities and good roads for all the year round motor travel, or it may be larger than some of the Eastern states, without railroads at all and with such roads as there are impassable for a part of the year. It may be rich and prosperous, or it may be poor and unproductive. The people themselves may be of mixed color, nationality and religion, or they may represent a single type of American citizenship.

If there be a county health department, with county headquarters and a full time salaried health officer, plans for the nursing work will naturally form part of a county health program which must be worked out in council. If the nurse is the

[3] Dr. W. S. Rankin, "Report of the Committee on Public Health and Sanitation," *Proceedings of the Second Annual Country Life Conference.*

only salaried full time health agent she will be expected to work out her own plans, and for this a due amount of time must be taken. The county seat is usually the logical place for headquarters and, if possible, room for an office should be found in the building where the other county agencies are housed. In this way the nursing work will be properly allocated in the minds of the people.

Many county nurses begin their work as specialists, perhaps as school nurses, children's nurses or tuberculosis nurses. While such an arrangement may be necessary owing to the sources of financial support, it is not usually desirable. Dr. Dearholt says, "It is not profitable to spend too much time in an effort to tease out the tuberculosis thread from among all the other threads,"[4] and this is equally true of other special types of work. A county, if it have but one nurse, needs in her a woman who will consider all its health requirements, and who will place no undue emphasis on any particular phase of the problem. Successful county nurses who are specialists have rarely found it possible to keep to their specialty if they have attempted any broad program of work.

What, it may be asked, is a broad program of work, and what is the real objective of a county nurse's work? It is obvious that one woman assigned to a county the size perhaps of the State of Connecticut cannot expect to do everything, or even to accomplish anything at all unless she plans her campaign carefully and with a view to wise elimination. Her objective must naturally conform to the conditions of her work. If she is the only nurse she will probably have for an ultimate objective such an exposition of public health nursing as will eventually lead to the employment of nurses in sufficient numbers to meet the needs of the county. If her county is already in a measure adequately served, her objective, though ultimately the same, will in its nearer aspect be such a coordination of existing forces as will hasten this end. In making her plans she must remember that an ultimate objective is never quickly reached. Very possibly even the youngest county nurse will not live to see the

[4] "Methods of Administration and Management of Health Problems in the State of Wisconsin," Dr. H. E. Dearholt, *Proceedings Second National Country Life Conference.*

rural districts of her county adequately served, but it is a comfort to know that even the oldest will see distinct changes for the better.

In arranging the year's program the difficulties of winter transportation must receive early consideration. It may be necessary to change a desirable sequence of undertakings in order to get to remote parts of the county while the roads are passable. If certain localities are already fairly well cared for these may be left alone and the time given to other less favored districts, though a county nurse should know something about her entire county and should certainly be on friendly working terms with all her co-workers, particularly those of her own profession. Indeed, since county nursing implies the covering of considerable territory, there is no type of work which so taxes a nurse's ability to work through others, and this must be done not only through co-workers but through the organization of local forces, for the nurse who relies on her own efforts alone will be even less successful in county work than in other forms of public health nursing.

For the enlistment of local interest careful plans must be made, for it is not easy either to inaugurate group action or to develop the required leadership. Everything in the life of a farmer makes for a greater individualism than is the case with the city dweller, and in an effort to overcome this natural tendency in favor of more concerted action a true understanding of the farmer's point of view must be had. If the nurse herself is country bred this should not be difficult, though often there is no one so intolerant of old methods of thought as the recent convert to new ideas. If the nurse is unaccustomed to the country she should make a determined effort to overcome her ignorance. A certain amount of help will be found in reading on rural subjects, but all the theoretical knowledge in the world will be useless unless she is successful in making the personal contact. The best way to understand a people whose traditions and present circumstances differ from one's own is through friendly relationships and a deep-rooted sympathy that takes little account of superficial differences because it is founded on those qualities which are alike in all. Certainly no health measures inspired from without are likely to secure anything

but very ephemeral success. In developing her program, therefore, a nurse should work very closely with the county medical society (if there be one), with the county agricultural agent, the Young Men's Christian Association representative and such other individuals as are working on a county basis.

In the clergy and the school teachers she should find her greatest allies. Indeed without the latter she will hardly be able to progress at all, and through the former she will be able to enlist the interest of women's groups such as Ladies' Aid Societies and others of a like nature. The local press may also be of great help. Sometimes it is possible to organize health clubs or study classes on a county basis, with local branches having representation in a central council. Farm institutes and county fairs have proved of inestimable value to rural nurses in their health propaganda. A health booth at the county fair, with a rest room for women and a day nursery for children, often does much to bring the nurse's work into prominence and pave the way for more permanent effort.

Office hours at headquarters on a regular day of the week are almost indispensable if all the desired relationships are to be cultivated, and a rest room, open on Saturday afternoon or on market day for farmers' wives who come to town, has been found extremely profitable in forming pleasant connections which lead to helpfulness. Sometimes health talks are given at the rest room or health literature distributed, sometimes nothing so definite is attempted, but the mere regular attendance of the nurse is found sufficient to open the door for inquiries, and to bring in many who need assistance.

A good nursing committee is the best augury of success that a nurse can have. When county nursing has been started under the Red Cross or other private agency such a committee has usually guided its work, and may be continued, with slightly different prerogatives, when public responsibility is assumed. A discussion of the functions, relationships and personnel of nursing committees will be found in earlier chapters.[5] Their value to nursing work, whether privately or publicly administered, cannot be overestimated.

In beginning work the schools have as a rule been found the

[5] Part II, Chapters 2 and 3.

best door of entry. In choosing such a starting point, however, care must be taken that the school child be not considered alone, but that family health be made the true basis of work. To secure this, and to lay a firm foundation on which to build, a certain amount of home visiting is indispensable, and in such visits no aspect of the family health must be slighted. It has been said that for success in farming the health and ability of the farmer's wife are just as important as the health and ability of the farmer himself, and the farmer's children certainly prove the truth of the assertion in another generation. In visiting a school there are three elements to be considered, the teacher, the children and the parents. On the whole it has been found that class-room teaching of health is best done by teachers rather than by nurses.[6] This does not mean that nurses can wash their hands of this responsibility. Many teachers are not yet equipped to teach health subjects and they must continue to rely on nurses for very definite help in arranging this part of their work. Though a short health talk from the nurse will usually be found desirable at each school, this should be only supplementary to more regular instruction given by the teacher each day or week. Such questions also as sanitary improvements in the school house, proper ventilation, hot lunches for the children, etc., must actually be attended to by the teacher, though the nurse may perhaps be the one to initiate reform.

A group meeting with mothers is usually arranged after school hours, and both this and the talk to the children should be carefully planned and the temptation to cover too much ground resisted. The subject of prenatal care should be opened in such a way as to pave the way for questions. At the close of the mothers' meeting general questions will naturally be encouraged, but time should also be allowed for personal talks with individual mothers. Home visits should be made on the parents of children showing physical defects, and these visits give an opportunity for helpful advice about other members of the family. The baby and other small children will naturally claim attention, but the health of their father must be considered as of no less importance. Sanitary conditions, the cleanliness of the milk supply, overwork, and all of the well-known health problems

[6] See Part V, Chapter 5.

will be found in rural work as in city work, and must be wisely dealt with by the usual methods of education for the individual and the slow influencing of public opinion. It is not now thought that outdoor farm work is in itself bad for women if the work is not too heavy and the hours too long, provided of course that such work is not done in addition to long hours of indoor exertion, an important proviso. Rural child labor is a serious difficulty in many communities, and county nurses should make themselves thoroughly conversant not only with local conditions in this respect, but with the best opinion on the subject, and also with the laws of the state regarding it.

The question is often asked, shall a county nurse attempt bedside nursing? There have been various answers, and no hard-and-fast rule can be laid down, but on the whole it is felt that no nurse can afford to appear indifferent to the call of suffering, or lose entirely the advantages of such contact. Of course it is impossible for a single nurse in a large county to work as does the city nurse in a small district, and she must avoid allowing herself to be so tied up with a few bed patients in a restricted area that she is useless to the rest of her county. All bedside nursing should as far as possible be demonstrative in character, and every effort made to teach others how to continue the care, though occasionally a life may be saved by a few days of continuous skilled nursing, an opportunity for service not lightly to be ignored.

In case of epidemic, disaster, or any other unusual demand, all routine work should be abandoned and the time of the nurse given entirely to the emergency situation. Often the mere presence of one who can speak with authority inspires courage and raises the morale at such a time, and there is always very definite work to be done not only in the way of individual assistance but in organizing local forces.

In many counties the questions of medical diagnosis of defective children and subsequent treatment are very difficult ones. It is all very well for teachers and nurses to discover conditions which require attention, but what is the good of this if nothing can be done about it? Sometimes the difficulty lies in the unsympathetic attitude of the local medical profession, sometimes

in the scarcity of doctors or even in their total absence. The first difficulty can often be met by bringing the subject before the county medical society or some other representative group of doctors. Where no such bodies exist the local doctors may be asked to meet together to consider the matter as presented by the nurse. The necessity for the assumption of responsibility usually awakens a sympathetic attitude in the minds of the most conservative. In making any such presentation a nurse must be careful to avoid arousing antagonism by a critical attitude toward existing conditions, or by over-emphasis on accomplishment elsewhere. Generally speaking it is unwise to seek outside medical assistance for individual cases, such for instance as that which may be obtained at the county seat, until all local resources have been exhausted, unless it is the consensus of local medical opinion that such an arrangement is desirable. Certain exceptions to this course will perhaps be found necessary, but the fact must be recognized that the nurse who tries to establish a health program without the support and sympathy of the local medical profession is building on unstable ground.

The scarcity of doctors in rural communities presents a very real problem and one for which rural America has as yet found no solution, though suggestions of various kinds have been made by students of the subject. Among them is state subsidy for rural physicians, the establishment of state subsidized county hospitals which will simplify the doctor's work and stimulate his interest, arrangement for diagnostic centers served by visiting doctors, and other suggestions of more or less far-reaching purport. Perhaps the obstetrical problem will be solved through the training of American nurses for maternity work, like their English sisters.[7] Meanwhile the county nurse, a trained individual whose primary interest is health and who gives her whole time to its promotion will undoubtedly help to create a public opinion which will eventually have its effect in a demand for better service.

A number of interesting devices have been tried for arousing interest in rural health matters. The health truck and the

[7] Those who believe that provision for an adequate medical obstetrical service is not only desirable but possible in America consider that such a plan is destructive. Others feel that results in England justify emulation.

health railroad car, equipped for clinic work and manned by doctors and nurses, the Ford car lecturer who tours the country delivering health lectures from the car itself, the motion picture film, the traveling exhibit, have all undoubtedly helped to do what in American slang has been called "selling the health idea." Many of these schemes, however, like the revivalist meeting, are of doubtful permanent value unless succeeded by a steady continuous influence leading in the same direction. Health literature is another aid which cannot be ignored and the valuable bulletins of the Children's Bureau, and other publications of a like nature, will be found of distinct help and can be obtained free or at nominal prices.

A number of counties are arranging for consolidated school districts with well-equipped buildings comparing favorably with the best city school houses. Where these exist the nurse has ready to hand an excellent plant for the establishment of health centers, but without this satisfactory equipment it is still possible to carry out the health center idea in even the smallest rural school house if the nurse and teacher are able to enlist local interest and focus attention on health matters.

In the past the rural nurse has found little precedent to rely upon, but that situation is changing. Not only are many other nurses besides herself at work in the rural field,[8] but a number of experimental demonstrations are in process, financed by the big foundations and carried on by one or another of the national health organizations, and from several of these valuable data regarding rural work on a county basis will, in time, be available.

Looked upon as a final result, a single nurse, set down to work unaided in a county comprising hundreds of square miles of territory, without adequate health machinery and without even the support of a general public opinion, is, to say the least, a pretty unsatisfactory achievement. Looked upon as an opening wedge for future development, is she more of an anomaly

[8] "In 1909 there were in the United States but 12 organizations with 20 nurses providing county-wide service. In 1922 there were 957 county organizations with 1,434 graduate nurses. In 1909, 1 nurse in 70 was a county nurse. In 1922 the ratio was 1 nurse in 8." Article by Mary Augusta Clark, Consulting Statistician, National Health Council, *Red Cross Courier,* September 1, 1923.

than the single nurse who started district nursing in New York City no longer ago than 1877?

There is no truer adage than that which says that "in doing is the knowledge won to learn what yet remains undone," and the county nurse who works well and thinks intelligently is sure to do much more than affect the limited area in which her work lies, for she is blazing a trail that will in time become a broad highway.

Chapter 3

MUNICIPALITY

It was twenty-one years after the first district nurse made her appearance on this side of the water before public health nursing was undertaken by a municipality.

The city of Los Angeles led the way in 1898 by the appointment of a single municipal nurse. For some years the experiment seems to have made but little impression on other American cities, but of late a marked tendency toward this type of control is evidenced, and the development of municipal nursing has been extremely rapid. On the whole the West is more advanced in this matter than the East. Possibly this is due to the fact that in early days private agencies were established in greater numbers in the East, thus solving the problem of the care of the sick at home and delaying the moment when public opinion should demand municipal interference. The nursing ventures of an Eastern city are therefore older and are apt to resemble its city streets, a patchwork of unrelated efforts that must later be brought with difficulty into proper relationship to one another. In the West, on the other hand, work was not begun at so early a stage of the public health nursing movement, standardization had been carried further elsewhere, there was more of precedent to study, and the seed of municipal work could in many instances be planted in quite virgin soil. Also a late entry into the field found women in politics and in general a more fully awakened civic conscience. In the West there has certainly been less necessity for adjustment of already established private agencies, and less to overcome in the way of prejudice against public control. On the whole, since 1916 the growth of municipal work throughout the country has compared favorably with that of private agencies.

A study of the successes and failures of municipal nursing would seem to show certain well-defined causes. In most

instances failure has apparently been the result of deviation from methods which have long proved successful under private control; for experience shows that there is less diversity between private and public agencies than was at first supposed, and consequently less necessity for different methods of handling situations common to both.

Municipal work reaches a higher state of efficiency where a separate nursing bureau exists, and where this bureau is in charge of a chief who is herself a nurse. Dr. Winslow says, "The morale of a staff is always highest when under the direction of a professional colleague who really understands the procedure of nursing. True democratic leadership over a group is possible only when the group is conscious of superior skill based on training and experience in the details of the work, and the consequent ability to render help in the solution of the problems of the individual members of the group."[1]

Nothing is truer than this, and, entirely apart from efficiency of work which is almost invariably increased by nurse directorship, the psychological effect on a staff of the leadership of a member of the same profession is far reaching. In addition a better distribution of the staff is possible under a centralized bureau. Nursing work is always more or less influenced by the season, and a chief nurse should be free to transfer the nurses from service to service as required.

More satisfactory results are also obtained where the bureau of public health nursing operates under a separate budget. The director can then make her plans in the light of a definite knowledge of her annual resources, she is saved from the undignified necessity of begging for what she needs, or of accepting appropriation grudgingly withdrawn from other uses, and she becomes interested in wise and economical expenditure. Women have been found to do extremely well under the budget system. Once interested, they become careful and wise spenders of public funds.

Whatever the form of administration for the various fields of work, all the nurses should be ultimately responsible to the chief of the Bureau of Public Health Nursing. This sometimes

[1] "The Ideal Health Department in a City of 100,000," prepared by Dr. H. P. and I. Harris, Department of Public Health, Yale Medical School.

presents a difficulty, for when nurses are working under a variety of departments or bureaus each department or bureau chief not unnaturally desires an exclusive control. In some cities the difficulty is still further increased by the fact that the school nurses work under the board of education, while other nurses are employed by the board of health. Such situations, though not perhaps wholly easy of adjustment, need not prove an insuperable obstacle to the amalgamation of the entire nursing staff under the nursing bureau. Special groups of nurses may continue to work under the medical officers of other departments, being responsible to them for all the details of actual daily routine, but with an ultimate responsibility to their nurse director. With a little adjustment, and an effort to understand the various requirements and points of view, a working basis can be devised, and a better selected, better instructed, and better supervised staff built up, and a better esprit de corps maintained than under any other conditions.

Adequate supervision of the staff by properly equipped nurse supervisors is of vital importance. It has been estimated that for a staff of fifty nurses at least six supervisors should be provided.[2] Many private organizations place this number higher.

The appointment of nurses to the staff is variously arranged in different cities, the chief nurse sometimes having a very free hand in the selection, and sometimes having no power whatever in the matter. Any automatic system of appointment, like that of the civil service, by which the first woman on the list must be given a trial, and perhaps retained regardless of her personal qualifications, results in a most expensive form of labor turn-over, or, still worse, in the retention of incompetent nurses. Not only is there the waste of poor work done by such appointees, but a waste of the expensive time of supervisors and chief nurses spent on women incapable of benefiting by education. The residential qualification, whereby only local nurses may be employed, has also been found to be a handicap in securing the best qualified women, though public sentiment on this point must receive a certain amount of consideration. Where the civil

[2] "An Ideal Health Department for a City of 100,000 Population," prepared by C.-E. A. Winslow, Dr.P.H., and I. Harris, Department of Public Health, Yale School of Medicine.

service system obtains and a chief nurse does not have immediate power of appointment, she should be allowed wide powers of recommendation. Good work cannot be done by inefficient or incapable workers. This is a truism, yet much money is spent annually on partial successes or absolute failures, through non-recognition of the fact that ill equipped or personally unqualified women cannot perform the difficult work required of public health nurses. Not only is a wiser selection made by a woman of the same profession than by a stranger to its requirements or through an automatic system, but focussed responsibility reacts favorably on everyone, and a chief nurse's success in obtaining results is apt to be in fairly direct relation to the freedom allowed her in selecting the material with which the work is to be done. A poor staff that she cannot improve is so discouraging as to kill ambition in the most hopeful heart.

The ordinance creating the service should provide for a minimum requirement for the qualification of nurses. This can at least secure a graduate staff. Such provision simplifies the rejection of unsuitable women whose appointment is requested by politicians who feel that their demands should be heeded.

The pension system has been found in some cities to be a cause of difficulty, and about its advantages and disadvantages there is great divergence of opinion. Where the pension age is set at 60, a nursing staff is sometimes made up of an undue number of women approaching this age who quite naturally wish to continue work until eligibility for pension makes retirement on salary possible. Some women do the best work of their lives after fifty, but these are as a rule those who possess certain executive or administrative powers. There is danger that the average woman will lose her vivid interest in the people she serves if her work is too long continued under identical conditions. She might do well elsewhere, or at a different type of work, but who can blame her for perfunctoriness and an insistent lingering at an uncongenial task, when at the end lies a pension? Salaries paid through the more productive years, have in most instances been wholly insufficient to permit of saving for old age. There is nothing, however, so deadening to the vitality of a staff as a group of women who prefer old methods to new merely because they are accustomed to the old, who do no

progressive thinking, and who fear an increase in demands to which they feel unable to respond. On the other hand there are many who feel that the pension system is of value in doing away with at least a certain amount of dead wood, because even though a nurse may under it remain too long upon a staff a certain date is automatically set at which she will surely retire. Perhaps if the abolishment of the pension system could be accompanied by the payment of really suitable salaries during the best working years of life, voluntary retirement might be more usual.[3]

Most finance committees love increases in statistical data. So many thousand more visits this year than last is the slogan by which most budgets are raised, yet few stop to ask what a "visit" really is. Certainly it is not the mere physical presence in a house of a woman wearing a public health nurse's uniform. Yet some of the visits which make such a brave showing in annual reports mean, quite literally, nothing more than this. Where the ratio per visit per nurse is unduly high, it means many five minute calls, and there are very few five minute calls that are worth the making. Even when plenty of time is taken, a nurse may spend half an hour wholly unproductively. It means nothing that she should talk fluently on matters of health, the only gauge of success is what she leaves behind her. If she leaves nothing the money spent on the visit has been spent in vain, though on the statistical report it will have equal value with one that is worth all, and more than all, that it has cost.

There is of course a certain amount of inevitable failure in any work in which the personal equation plays so important a part; and the difference between good, mediocre, and poor work is not always easy to distinguish by those unused to such analysis, but an experienced supervisor knows by a study of conditions the limit beyond which such failure ought not to be permitted. It certainly may safely be said that a good staff, carefully selected and properly supervised, has been found a wise investment by practically every community. On the other hand a poor staff appointed by those unused to the evalu-

[3] For further discussion of the civil service system and life tenure see Part III, Chapter 1.

ation of nursing qualifications, improperly supervised, and retained beyond the point of usefulness, lays a burden on the tax payer for which there is no commensurate return.

We have heard much of the difficulties of the municipal nurse and her superior officials, and particularly of the lack of understanding often accorded her work by those upon whom she must depend for policy. This is most natural, for at the present time the work of both health officer and nurse lacks standardization because both of them are passing through a period of transition. Old methods are in both cases giving way to new, while the whole emphasis on health problems in their countless aspects has been continually changing. Naturally these changes of thought and action have not taken place at a uniform rate of speed in all lines of work, and, as might have been expected, many nurses with advanced views have found themselves associated with health officers holding quite different opinions of the functions of a health department, while in more instances than we always care to remember the reverse has been the case, and a progressive health officer has been unable to carry out his plans because the nurse was incapable of appreciating their significance. A nurse and a health officer of thirty years ago would probably have worked together in the greatest harmony had it so chanced that their paths crossed, for their training in health thought, and their consequent point of view, would have been the same. So, without doubt, will the nurse and the health officer of ten years hence, for each year sees not only improving educational opportunities for both, but each year is emphasizing for both the interdependence of their work, and the common point of view.

Most public agencies have in the past confined themselves more or less strictly to instructive work, leaving to private agencies the bedside care of the sick. If generalized nursing is to replace specialized nursing this division of labor must be changed; and if, as is so frequently suggested, the entire responsibility for the public health nursing of a city is to be assumed by the municipality, bedside care will naturally form a part of every nurse's work. For this inclusive program a large appropriation would be required, and the question of the desirability of working on a fee basis arises. Few public

agencies undertake bedside care, but where done it has been an almost universal rule that the services of the nurses should be free to all. Two opinions are held on this point:—one, that municipal nursing, paid for as it is by the tax payers' money, should be as free as education, or police and fire protection; the other, that the heavy expense of a public health nursing service may well be met in part by those making use of it, thus lightening the load for the other tax payers. In the report of the Committee on Municipal Health Department Practice, the following statement is made: "There is no substantial reason, aside from tradition, why such service (a complete nursing service) should not be in part supported, so far as bedside care is concerned, by payments from patients able to pay and from insured and other groups, although this may require special enabling legislation in many cases."[4]

There is one point of difference between public and private enterprise which, though not universal, is sufficiently marked to demand attention. Practically no private nursing organization attempts to administer its nursing affairs without giving considerable time in board or committee meetings to the guidance of policy. Most private organizations have in addition a special nursing committee whose function it is to attend to matters of greater detail. On their boards and nursing committees nurses have long learned to lean heavily for the guidance and backing that makes pioneer work possible. Group consideration of any subject is an enormous help to wise decision, and such boards and committees in addition to the guidance of policy do much to interpret nursing work to the public which they represent.

Comparatively few public bodies have availed themselves of this means of grace, though those that have done so find such committees of great value. We hear constantly of the dangers of political interference in publicly administered work. In some health departments the accusation is undoubtedly just, in others there is no such trouble. In any case a committee of interested and informed citizens, primarily interested in nursing, and meet-

[4] "An Ideal Health Department for a City of 100,000," *American Journal of Public Health,* November, 1922.

ing at regular intervals to uphold standards and further the work, acts as a wonderful stimulant to those in authority.

Nursing committees when attached to health departments are usually advisory committees, and it has been felt by some that this is a disadvantage because it is difficult to persuade busy men and women to serve on a committee that is without power. An advisory committee if made up of the right men and women can, however, be exceedingly powerful provided it has public opinion behind it, and recommendations made by it are likely to carry considerable weight.

The creation of such a board or committee should not be left to the individual judgment of a public official but should be created by definite city ordinance. The ordinance should define the duties to be performed and the number and personnel of the committee (how many men, how many women, the agencies to be represented, etc.) It is also desirable that the ordinance should make definite provision that the committee act in an advisory capacity on *all* matters of policy, thus securing a consideration of all important issues.

If a large part of our privately controlled work is eventually to pass into the hands of governmental bodies, it would certainly be a pity if the interest and knowledge now available for the work should be withdrawn. Unless, however, a nurse has the same opportunity that is accorded in private organizations, to meet with her municipal committee and freely discuss with it her difficulties, there will be little use in its appointment.

A careful analysis has been made of the number of nurses required to meet adequately the needs of a city population, and a nursing service equivalent to the following is suggested for a city of one hundred thousand inhabitants.

	Nurses
For communicable disease control	1
For tuberculosis control	4
For venereal disease control	2
For infant welfare work	15
For school health work	8
Total	30

This number will of course be differently distributed if the work is generalized, and if bedside care is given twenty more nurses will be required, making a total staff of fifty for a city of one hundred thousand inhabitants. It is further suggested that in this case the city be divided into forty districts of approximately 2,500 persons each, and that the additional ten nurses be unassigned and used to meet emergencies and cover vacation periods.[5]

While these figures suggest a staff in excess of the number usually obtainable at present, an ideal toward which to work is both helpful and stimulating.

The charge of inelasticity is occasionally brought against publicly administered nursing work, and it is said that new ideas do not obtain a ready hearing. It is probably true that a private agency can more readily enter upon an untried field of experimentation. A public agency will always, and probably wisely, err on the side of conservatism. It should, however, hold itself in readiness to adopt such new methods as have proved their worth, and to accept no standards but the highest.[6]

There is no reason why the best nursing work in the country should not be done under municipal control, but to get the best results the finest type of women must be attracted to the field, and find in it full opportunity for the use of their powers. There are so many openings for nurses of ability now that the best will inevitably drift away from positions where opportunities for service are limited by a narrow-minded administrative policy, leaving behind them a residue of the less efficient and the less progressive. No municipality can afford this, and the fine work now done by many cities, large and small, may well serve as examples of the possibilities of well-administered municipal nursing.

[5] "An Ideal Health Department for a City of 100,000," *American Journal of Public Health,* November, 1922.

[6] Corporate membership in the National Organization for Public Health Nursing has been found extremely helpful in securing standardization.

PART IV

THE NURSING GROUP

Chapter 1

FROM THE NURSE'S POINT OF VIEW

As a woman stands on the threshold of her nursing career, with the decision before her of which way to turn her steps, she may well take time for consideration. It is sometimes a difficult matter to extricate the round peg from the square hole, and valuable time may be lost in the process.

There are three things every nurse has a right to seek in making such a decision: first, that the work she chooses should be worth doing; second, that it should be done under conditions that destroy neither her health nor happiness; third, that she should receive for it a suitable financial remuneration. In addition, she is quite justified in considering the effect of her work upon herself and her own development.

Let us look at public health nursing in the light of these requirements.

The first requirement, that the work be worth doing, is certainly met in the public health field. Indeed, without the public health nurse present-day health programs would be impossible, for the part she plays is vital to them. Nor could the work itself be at a more interesting stage of its development, or one in which the best type of woman is more needed. The first experimental stage is over, and a sufficient number of years have passed since the simple beginnings of the early district nurses proved the need of such work the world over. Moreover, within the last few years it has become possible to reckon results with a fair degree of accuracy. We know for instance that with a given number of nurses working under prescribed conditions the infant death rate in any community can be reduced to a certain, definitely known degree. The satisfaction of assured achievement may therefore be counted as one of the advantages of public health nursing. Yet on the other hand the movement has not yet reached its maturity, and, as in all new

enterprises, the worker has the stimulus of the enthusiasm and rapid growth common to all young life.

The field has never been a crowded one, but since the great impetus given health work by the war the demand for good nurses has far exceeded the supply, and no one need feel that in becoming a public health nurse she is joining an already sufficiently large army. Recruits both for the ranks and for executive offices are still greatly needed.

Granted then that public health nursing is worth doing, and that there is room for new recruits among its ranks of workers, we may pass on to the second requirement, that in respect to the healthfulness of the life and the relative happiness of the nurse in it.

Public health nursing has now become so inclusive a term, embracing so many fields of activity, that it is difficult to generalize in regard to it. In the greater number of its branches, however, home visiting is implied, which means outdoor life, and though night work is more usual than formerly, the demand is not as a rule heavy, and time so lost is if possible made up. The out-door life and prescribed hours make public health nursing for the average woman a healthful form of work. It is, nevertheless, hard work, and no account can be taken of heat or cold, wind or storm. For a nurse therefore with physical weak points, such as a delicate throat that succumbs to constant exposure, or a heart that makes much walking and climbing of stairs undesirable, other work is probably better. The word "probably" is used advisedly, because many nurses, who in private or institutional nursing have been far from strong, have found that the greater regularity of their night's sleep and the increased appetite produced by the out-door life have more than compensated for the hardships of exposure to weather.

While arrangements differ in different organizations and with different types of work, where a number of nurses are employed Sunday duty is taken only in rotation. For those engaged in special work Sunday is usually a free day and for the nurse working alone it is made as easy as possible. One additional free afternoon is allowed, and it is almost universal for public health nurses to receive one month's vacation with salary.

This is sometimes dependent upon the nurse's continued connection with the organization, though as a rule the twelfth month of each year of work is given irrespective of future plans.

It is difficult strictly to regulate the daily hours of work because of its fluctuating character, but there is a growing conviction that certainly not more than eight hours should be required, or indeed allowed.

The regularity of the life is in many instances a matter of individual good management. Some nurses are able to cease their work with almost the same promptness with which it is begun in the morning, while the lunch hour is taken at the appointed time as a matter of course. Others constantly find it necessary to work overtime, and make of the noon meal a movable feast to be partaken of anywhere between the hours of eleven in the morning and three in the afternoon. For the latter type of nurse indigestion and fatigue are common, but these dangers are not inherent in public health nursing, as every supervisor will affirm, for the best managed district will usually be found to belong to the nurse who so plans her work that, except in emergency, she gains for herself the advantage of regularity of hours for food and rest.

Whether the life of the public health nurse is a happy one, must be to every individual woman a personal question. Unless the work itself brings happiness she will be wise to turn to something else. Otherwise the poverty and suffering among which her days are spent will prove hopelessly depressing. The nurse who takes up public health nursing because the hours are short, or the evenings free, and who lives through the hours of her working day in order to enjoy these advantages, rarely meets with enough success to insure a happy life even though she conscientiously means to do her best. Unsuccessful public health nursing has its own peculiar disadvantage, for not only is there the discouragement of personal failure, but, it is so linked to other forms of work by the cooperativeness of its character, that weakness or failure means loss of strength to other social forces. Even if unconsciousness of this fact blunts its worst discomfort for the nurse unable to see the opportuni-

ties she is missing, others are not so blind, and short shrift is apt to be given the worker responsible for such a situation.

Fortunately it is not often that the work is not enjoyed by the nurse who has chosen it. There is intense gratification to be found in a good health program, and working out new plans for its advancement and identification with the varied interests of community life are of themselves stimulating experiences. Affection and gratitude also flow forth so freely from the patients, there is so much room for individuality of thought and method, there is so little of monotony and so much of variety, so many different types and kinds of people are encountered, and, above all, tangible results are so plainly seen, that for the right nurse the life is full of absorbing interest. Nor do the hours of work form the whole of a public health nurse's life. She has the opportunity to develop other sides of her nature. The shorter working day and the assured freedom of her evenings and Sundays, make possible other interests and pursuits, and, as a rule, public health nurses are found to avail themselves of these possibilities, often pursuing courses of study far removed from nursing, or turning their attention to music or painting on free afternoons or evenings. The broadening effect of these outside interests is quickly reflected in the nurses' character, and does much to prevent, or relieve, the wear and tear on the nervous system produced by a single mode of thought and occupation.

It may also be accounted an advantage that home life is possible for nurses fortunate enough to find positions in their home town, though in such an arrangement household duties must be left to others, for after her day in the district a nurse will not be able to set about another form of mental or physical activity the moment she enters the house. This is not expected of a man, and should not be expected of a working woman.

It is difficult to discuss the third requirement, that concerning suitable remuneration, because the whole question of salaries is in so unstable a condition that any statement regarding them is of little value. Efforts have been made at various times to standardize salaries throughout the country, but without success. The cost of living is so different in the city and in the

country, and varies so much in different cities, that a salary which affords comfort in one place means positive poverty in another. Moreover, it has been found necessary to reckon somewhat with the law of supply and demand. An isolated, trying position is not easily filled, and this fact must be taken into account in securing a nurse. It may be said in general, however, that, as better prepared women are entering the field and more specialized training is required, there is a tendency to raise salaries in all branches of the work. At the time of writing (1924) salaries for staff nurses run from one hundred dollars a month to one hundred and twenty-five or one hundred and thirty, with a few still higher in cities where living expenses are exorbitant or where the position is a difficult one. A sliding scale is adopted by many organizations by which an increase is automatically made each year of the nurse's stay, the maximum being reached in most cases at the end of the first two or three years. The salaries of supervisors, consultants and teachers depend largely upon the amount of responsibility carried and the personal equipment of the individuals. Perhaps the average supervisor's salary may be stated as from fifteen to eighteen hundred dollars a year, though there are a number lower. On the other hand the college graduate who has added to her hospital training a good postgraduate course in public health nursing, and the woman especially fitted for consultant service, can command more in a supervisor's position. Directors' salaries run from eighteen hundred or two thousand to three or four thousand dollars and occasionally higher, depending on the size of the staff, volume of work, educational responsibilities assumed, cooperative demands, personal experience and ability, etc. On the basis quoted here living expenses are not included, nor as a rule are uniforms furnished. The latter, however, are required and may usually be purchased at special prices. It is almost universal to allow one month of vacation on full salary, with the stipulation that no nursing shall be done for remuneration during this period. In the East, governmental salaries are apt to run a little lower than those of private agencies, and in the West, a little higher. The pension system obtains in some publicly administered work but is by

no means universal. In private organizations it is practically unknown.

It may be felt that, compared with the salaries paid to private nurses, the salary of the average public health nurse does not make a very good showing, and in the short run this is true. In the long run, however, the scales do not tip so heavily to the side of private nursing. Even the most successful private nurse must lose a certain amount of time between cases, and her vacations and periods of illness cause a complete loss of income. If the nurse is not unusually strong this loss of time increases as she grows older, for the exigencies of private nursing are hard on health. The public health nurse, on the other hand, is apt to lose very little time. Her night's rest fits her for her day's work, her free afternoons and Sundays for her week's work, and her month of vacation for her year's work.

Policies differ with different organizations in regard to sick leave, but a certain automatic allowance for illness without loss of salary is quite general. Two weeks during each year is perhaps the most usual arrangement. Cases of illness prolonged beyond this point are considered individually, and decisions regarding continuation of salary or part salary are based on whether or not the illness was contracted in the line of duty, the average time lost by the nurse during preceding years, her value to the organization, etc., etc.

Taken over a period of ten or twelve years, there is less difference between the total receipts of the public health nurse and those of the private nurse than might be expected; and if there is a difference in that most important financial asset, physical health, it is likely to be to the advantage of the former. Moreover, experience in most instances increases the earning capacity of the public health nurse, and this, for some inscrutable reason, is not usually the case with the private nurse. Public health nursing may be said to compare favorably financially with institutional work though an institutional nurse is assured of hospital care in case of illness. This is not infrequently arranged for the public health nurse, but it cannot be counted upon. For the average good nurse capable of attaining success anywhere, the public health field taken over a period of years is now perhaps as well paid as either of the

other two branches of nursing. A steady and assured income may be relied upon, and positions are plentiful. To the exceptional nurse with executive and administrative ability, good salaries are offered, and for all, the tendency is toward greater remuneration as the standard of efficiency is raised.

The query as to the effect of public health nursing on the character and development of the nurse herself can be spoken of with some assurance.

It is a truism that one gets from anything only what is put in, and some of the finest and broadest characters have been developed under adverse circumstances. On the other hand the most favorable conditions fail to jog other women out of their narrowness and self-absorption. It may be said of public health nursing, however, that it is difficult for those engaged in it to escape development of character. A public health nurse represents advanced thought on her special subject and her intelligence and originality are in consequence stimulated; she works with so many types of people representing such different points of view that she learns that other elements in her patients' lives are quite as important as physical health, and this broadens her outlook; she sees her patients in the midst of their own natural environment and learns of their temptations, struggles and limitations and this teaches her sympathy and understanding; she deals with human nature uncontrolled by the abnormal restraints of hospital life, and she learns that she cannot always induce people to do as she wishes, and her own failures teach her tolerance for the failures of others; she carries her patients over long periods of time and they learn to love and depend upon her and this develops in her a spirit of tenderness and protection; and because her life is spent in dealing with people she learns that most valuable lesson, a knowledge of human nature, and her wits become sharpened by exercise.

These opportunities for development of character do not, of course, lie in the field of public health nursing alone, but they are to be found there, and are open to the nurse who seizes and makes use of them.

Owing to changing conditions, and the varying situations existing in different localities, it would be futile to suggest a

fixed line of procedure for a nurse who is intending to do public health work. It is safe, however, to urge that no one without either special training or experience should undertake it alone. If a nurse has no knowledge of public health nursing she will doubtless feel quite capable of giving the bedside care or instruction that her hospital training has fitted her to give, and which will perhaps represent to her all that will be required. Should she, at the request of a public agency or board of managers as ignorant of the subject as herself, undertake to start and carry on such work with this limited point of view, she will at best gain her experience at the cost of many unnecessary mistakes and considerable loss of time, and there is danger that she may never awake to the opportunities that lie on every side of her.

Wherever possible, definite postgraduate training is strongly advised, and time and money spent in obtaining it are sure to be well invested by those who desire to become truly successful in this branch of nursing. When this is out of the question, a subordinate position with an organization offering good educative supervision may be recommended. Even a few months of work under such teaching and supervision will open eyes that might otherwise be holden, and will prove a starting point for further effort along the right road.[1]

[1] For a discussion of public health nursing education, see Part I, Chapter 5, Section 1, also Part IV, Chapter 6.

Chapter 2

THE STAFF NURSE

The evolution of public health nursing in cities makes necessary a much more complicated organization than is required in small towns or in the country. The size of the staff is increased to meet the demand of the large number of patients; supervising nurses are appointed for the double purpose of arranging and supervising the work, and of relieving the staff nurses of duties not included in their legitimate task of home visiting; while for the same reason office help is furnished to reduce to the minimum the time that must be spent on clerical work.

As we attend national conventions and become part of the large audiences gathered together from every part of the country to discuss and consider public health nursing, as we visit the busy offices of the big city organizations and see the necessary paraphernalia of an active business enterprise, as we talk with representatives of state and city boards of health employing hundreds of nurses, as we meet with boards of managers composed of men and women giving time which in many instances is of great financial value, it is interesting to consider what all this is for.

Reduced to its simplest expression, this machinery has been brought into existence for the purpose of bringing care, instruction and help to the home of A and B and C, and that care, that instruction, and that help are brought there by the nurse, and the nurse alone.

In other words, all the vast machinery is valueless, without the nurse who brings her ministrations to the home, and the fact that the single home is multiplied by thousands only changes the situation in so far as it further emphasizes the importance of the actual point of contact, the nurse. Because the public health nursing movement has in its progress gathered about it

so much administrative detail, and because the cooperativeness of its nature has involved it in so many issues, the individual nurse working in her own small corner sometimes forgets that everything really exists for the sole ultimate purpose of making it possible for her and for others like her to do their work in the best way.

She is the great essential. With her began public health nursing when, under Mr. Rathbone's sole guidance, the work was started in Liverpool. With her as the great essential, it will continue as long as public health nursing is needed. And public health nursing will be approaching its end when the details of organization and administration, the necessary forms and ceremonies, are allowed to obscure the fact that that which really counts is the planting and tending of the tree, which "when the desire cometh is a tree of life." Many things enter into the beautiful mystery of growth, but the tools of ministration and instruction, the actual trowel and spade of the labor, are placed in the hands of the nurse who herself enters the home, and to her the whole organism must always look for the results of all of its complicated effort.

Let no public health nurse, therefore, feel that she bears an unimportant part in the great work of the movement. Let her rather rejoice in the dignity of her position, and rightly appreciate the fact that thousands of men and women in this and other countries so honor it, and so rate its importance, that they are willing to spend freely of their time and thought and money in order to build for her a foundation that will enable her to do her work to the best advantage.

The nurse who works alone has been considered in another chapter, because her duties and responsibilities differ somewhat from those of the nurse who is a member of a staff. For the latter, the complexity of city work would make satisfactory home visiting impossible unless she were relieved of many of the responsibilities of administration which form part of the routine of the nurse working in the country or small town. The staff nurse has as a rule no anxiety as to funds, no care of supplies, as little clerical work as possible, and she is not held responsible for the work of other nurses. Matters of general policy, too, are more or less out of her hands. Thus relieved

her time can be given to her own individual work; but this must not be allowed to fill her whole horizon, for no nurse, however situated, can accomplish her ends if she attempts to play a lone hand.

Too great emphasis cannot be placed on the value of team work. That an organization or nursing bureau is strong in the unity and loyalty of its staff, does not mean something vaguely desirable. It means that each nurse so believes in those things for which the organization stands that she is ready to sink her personal likes and dislikes, her personal preferences and irritations, in a general effort for good team work.

The atmosphere of an organization is quickly affected by the attitude of a single individual. If a nurse is not happy, or feels that she has just cause for complaint, she should go frankly to the right person, her supervisor or director, and tell her the whole difficulty, and she should keep her mouth very tightly closed on the subject to the wrong persons, the other nurses. If everyone complains ever so little, a sum total of complaint quickly rolls up quite capable of creating an uncomfortable atmosphere, and such complaint is utterly impotent, for nothing is righted in that way. Every director very honestly desires the happiness, as well as the welfare, of her staff, if indeed the two terms are not synonymous, and will be glad of the opportunity to act the part of a friend if she is permitted to do so.

As regards the important relationship of the staff nurse to her colleagues, the other nurses, a word must be said. It is natural and inevitable that some personalities will be mutually attractive and others just the reverse, and while a nurse may have the pleasure of working with a friend whose every action is satisfactory to her, her work on the other hand may bring her in contact with another who is antagonistic in every way. Neither of these situations must be allowed to affect her spirit or her work, for both have the power to do so adversely, the former no less than the latter. An intimate friendship may be allowed to become so absorbing as quite seriously to affect all the other relationships of life, and every supervisor knows the discomfort that such friendships are capable of producing in a staff.

If life is to be happily and successfully lived, the art of working with other people must be mastered, and though for some enviable natures no effort is required, the average nurse will find that she must quite consciously apply herself to the task if she is to fulfil her greatest usefulness as a member of a staff. A general acceptance of the basic principle that all the nurses desire, and are working for, one thing, the welfare of their patients, will bring about first tolerance, then patience, and finally appreciation and understanding of different methods of attaining the common end.

A nurse new to public health nursing often makes the mistake of undervaluing the importance of her reports to her supervisor. This is not unnatural. A head nurse in a hospital ward sees her patients constantly and requires from her subordinates merely such information as will keep her in current touch with their condition. A public health nursing supervisor, on the contrary, is more or less dependent for such knowledge on the picture drawn for her by the nurses who visit them constantly. If the reports are incomplete or inaccurate, she is unable to give the type of helpful advice that will lead to their best care. In addition, the nurse herself suffers, because it is largely through constructive criticism of her reported work that her experience is made educative.

The staff nurse who has had the advantage of public health training, in the form either of a postgraduate or undergraduate course, or the nurse who is working with an organization which provides instruction for the new members of its staff, needs no reminder of the importance of the social aspect of her patient's situations. There are, however, many staff nurses at work under both public and private agencies without these advantages, and such nurses must acquire the technique necessary for a proper handling of their cases. It is not to be learned in a day, but as the hospital teaches observation of physical symptoms, so the districts teach observation of social symptoms, and for the latter, as for the former, the power to see what is there to be seen can be cultivated.

Nowadays it is rightly felt that as grave an error is committed by the public health nurse who in the ordinary line of duty fails to notice that a child of school age is found at home in school

hours, as by the one who has not noticed that the patient's pulse is too rapid. In neither case is she expected to take active measures herself, but in both cases she is expected to notify the proper authority. In the case of physical symptoms the situation is simplified by the fact that it is always the doctor who is the proper authority, while with social symptoms the proper authority may be one of many agencies or individuals. A public health nurse on this account must form the habit of getting below effects to their causes. Though the truant officer might seem the proper person to deal with the child out of school, if the cause of absence is the fact that there is no one else to take care of the younger children during the mother's illness, it is useless to call him in. The proper authority in this case may be no farther away than the husband, who, if appealed to, could make arrangements with a friendly neighbor, or it might, on the other hand, be one of several charitable agencies. In any event, the important point is that the nurse knows three things: first, that something is wrong; second, why it is wrong; and third, what can be done to set it right.

To the nurse beginning public health nursing it sometimes seems as if an impossible demand were made upon her, but as she goes on with her work the observation of social symptoms becomes second nature with her, and once she has accustomed herself to see them other steps come more easily. She will find that she cannot enter a house without gaining a very clear idea of its sanitary condition, and whether or not there are enough rooms and enough beds to harbor decently the members of the household. She will know what care is provided for the patient, and if anyone is being taxed to the breaking point in order to provide it. She will know whether other members of the family are in good physical condition, and if the children of school age are in school. She will know whether the husband has steady work, and how many other members of the family are working. After a few calls she will learn whether any of the children are wayward or given to truancy. The sad tale of drunkenness will come out, or tiny straws will indicate the even sadder one of immorality.

All these things the experienced public health nurse knows with hardly the necessity of a question, and knowing them, she

has but to learn the ropes to set in train other influences for the benefit of the family. Results will not always be satisfactory, for too many doubtful elements enter into every social dilemma to insure success for the best laid plan, but the nurse will have done her part if board of health, charity organization, truant officer, children's aid society, settlement house, priest, minister, employer, or friend have been made use of as required. A straight course must, however, be steered between an undue interference and the necessity of rendering assistance that is not always desired. Just as a child may not want to go to school, counting as naught the education which later means so much to him, so many a grown-up child does not want to be helped to better conditions of living. Due allowance must be made for the habits of a lifetime, and time allowed to effect any radical changes; but it is wonderful how much may be accomplished by tact and perseverance.

All nurses are familiar with the patient who at first so rigorously objects to his bath, and all are equally familiar with the indignation of the same patient if later, after he has learned to enjoy it, his bath is for any reason delayed. There are many things like the bath which once accepted become matters of course; but much, infinitely much, depends on the personality of the nurse presenting the new point of view and the manner in which she presents it.

If her patience does not always hold out she must reverse the picture and imagine herself, without the intelligence that has been developed by her education, being persuaded by someone, perhaps younger than herself, of very likely an alien race, an alien religion and an alien language, to do something that neither she nor her ancestors have ever dreamed of doing before. Add to the points of difference the not unnatural attitude of suspicion engendered by generations of political oppression, and the wonder will be found to lie not in the failures, but in the successes of public health nurses.

The zeal of the new nurse usually makes the management of her day's work a little difficult. She finds it hard to calculate her time, and she is beset by the thought of a thousand little services by which she could make her patients more comfortable. These, when she cannot get them in during prescribed hours,

she may try to perform by increasing the hours of her working day, or by going without her lunch. If these methods are objected to by those in authority she finds it hard to reconcile such an attitude with real sympathy for the needs of the patient or his family. Here she must give time to thought, and endeavor to see the work of the organization as a whole, as her director and supervisors see it. They, too, would like to provide additional attentions for the patients, but the situation is not a simple one. On one side are a certain number of sick people to be nursed, a certain number of others to be taught by instructive visits, a certain number of clinics or baby consultations to be attended, a necessary amount of clerical work to be done, and, if the nurses' powers are to be developed, certain time given to conferences, lectures, and other forms of educational opportunity. On the other side lies the difficulty of procuring sufficient funds for an adequate staff, and the necessity of so arranging the work that it may be performed within hours and under conditions that can be maintained year after year.

A young nurse who is in a position to see but a very small part of the broad field of the organization's activities, should not too early attempt to judge of its methods. It is better at first to fall quietly in with the routine mapped out for her, conforming to all rules, and suspending judgment until a riper experience makes it possible to form a wiser opinion.

Of one thing every staff nurse may be certain, her director and supervisors are in thorough sympathy with her desire to do more for her patients than time permits, and if she is restrained it is because it is necessary in order to meet the heavy demands of the work, or possibly because they want her to learn the important lesson of teaching others to help themselves. When it is her own time, not the organization's, that the nurse wishes to spend, it may seem unreasonable that she should be prevented from doing so. While the motives that prompt such a wish are appreciated, it has been proved that in the long run the patients receive the best care from a staff whose enthusiasm has been kept fresh by a strict protection of their free time except in emergency or under unusual conditions. The nurse, therefore, who is thwarted in her desire unduly to spend herself must not allow her ardor to cool. She must, on the contrary,

make good use of it during the usual working hours, assured of the fact that her enthusiasm is not undervalued by those in authority over her.

The habit of promptness in the arrangement of work will facilitate its accomplishment. The temptation is often great to make one more call in the neighborhood at about the lunch hour, or to make a few extra visits at the end of the day, but once yielded to this temptation leads to a poor system of work. Emergencies will of course arise, but it has been found that on the whole the best work is to be had from the nurse who begins on time, who stops promptly at the appointed hour, and who arranges to take her luncheon quietly and peacefully at a regular time each day. The experience of thousands of good public health nurses has proved that this is possible, and that the nurse who never has time for her luncheon, and who is found constantly working overtime, is not more devoted to her patients than others, but is merely a poorer manager.

The work of a staff nurse varies according to the type of organization under which it is done. She may be engaged in some specialized form of activity controlled by either a public or private agency, she may be wholly occupied with bedside care, or she may be working in a small district under the generalized system where she is responsible both for the care of the sick and for all types of health teaching. If her work is specialized she must be very careful that her attitude of mind does not become narrowed to a single point of view. Family health is the goal of all public health nursing, and it is the duty of every staff nurse to try to secure this either by means of her own ministrations or through cooperation with others. This is quite as true of the nurse whose chief duty is the bedside care of the sick. Under the generalized system the just apportionment of time to the various demands will be found a difficult matter, for the tendency to respond to those that are most urgent, at the constant expense of the less urgent but equally important, must be wisely met. A nurse's own bent will inevitably influence her work to a certain extent, but she must be sure to perform first, and to the best of her ability, those tasks for which she is primarily responsible.

Certain requirements would seem fundamental in the care of

every patient: skilful nursing, such instruction of the family as will secure proper care during the nurse's absence, systematic teaching on matters of general health that will enable them to live wisely as far as circumstances permit, such specific instruction as is required to meet individual needs, a hopeful sympathy that will bring encouragement, and wise assistance in acquiring such other necessities, moral, mental or physical, as the exigencies of the situation may demand.

The first of these, skilful nursing, is sometimes so taken for granted that sufficient emphasis is not placed upon it. A perfect organization, a fine board of managers, a good director and a staff of nurses with diplomas from the best postgraduate schools in the country, may, however, be accounted as valueless if the patients are not well nursed, nor is it enough that a mere minimum of good nursing care be given in the districts. Because of the opportunity for instruction, and because the patient must be left for so many hours without trained care, every nicety of nursing skill must be brought into play. To those accustomed to the ameliorations of illness in the houses of the rich it is often a revelation what can be accomplished in the poorest homes. Many a poor patient after the nurse's call may be found in as exquisite a condition as the most carefully tended private patient except for the unimportant details of fine linen and luxury of surroundings. Standard methods of work have been developed to secure such results, and the first months of a new nurse's time will be profitably spent in the acquisition of this technique.

Experience develops the power of the nurse to work with what she finds provided, and also makes her more successful in securing the essentials from the family. What these essentials are will depend on the patient's condition, and what he has been accustomed to. Fresh air, clean bed clothes and a clean room, quiet, a sufficient quantity of the right kind of food properly prepared and regularity of hours for the administration of food and medicine would seem, perhaps, the minimum of requirements; but in trying to procure these requisites the nurse must remember that she is often expecting a revolution of methods in the household. Fresh air, if cold, is disliked, cleanliness may never have been considered important, quiet has probably never

been considered at all, regularity and system are in many cases unknown terms, and the lack of suitable food may be due to both ignorance and poverty. Therefore great patience is necessary as well as tact and persistence.

A wise nurse will make use of her knowledge of people, for often one person can be discovered possessed of that something, which under other conditions would be called executive ability, on whom real dependence can be placed. This individual may be the natural caretaker, the wife or mother, it may be the husband, it may be a neighbor or friend, or it may be a mere child. Whoever it is, much of the comfort and well-being of the patient will depend on the nurse's discovery of such ability and the use she makes of it. As we know the hours during which the nurse is away are just as important to the patient as the hour she is with him, therefore the instructions regarding his welfare that she leaves behind her cannot be too carefully given. If these include moving the patient or any form of treatment, the one to whom such care is entrusted should be carefully shown how to do it, not merely told. If on subsequent visits commendation is freely bestowed, the nurse *pro tem.* will be encouraged to further effort.

A real danger in the rapid development of public health nursing lies in the removal of responsibility from those who would naturally care for their sick. The nurse must try to foster, never kill, the desire to help, and she must learn to recognize this desire under the disguise of many queer performances, and make use of it, for after all it is the inalienable right of every individual to serve his own in sickness and trouble. Pride in nursing prowess can easily be awakened, and with an able colleague in the house everything is simplified.

Quite as important, however, as instruction in actual care is the atmosphere with which a nurse is able to surround her patients in her absence. Nervousness or nerve exhaustion are part of every illness, and because they are so little understood many a patient has been made to suffer miserably and most unnecessarily. If the condition of racked nerves is discussed as seriously with the family as some of the other more readily understood physical symptoms, and if alleviative measures, such as quiet, absence of worrying conversation, loud talking, etc.,

can be insisted upon, convalescence will proceed more rapidly. If, in addition, sympathetic kindness can be made to replace the irritation or joking intolerance so often meted out to the nervous sufferer by a well-intentioned family, much will have been done to ease the burden.

Not infrequently, where the case is a chronic one, everybody has, perhaps not unnaturally, grown tired of the situation produced by the patient's suffering, if not indeed of the suffering and of the patient himself. The genuine interest and sympathy of the nurse, and a little adjustment that will somewhat shift the burden of care, is often sufficient to fan the flame of family affection into life again. It is something for the nurse to remember that she may be, and often is, the only bit of brightness that enters the patient's room during all the dreary twenty-four hours. If kindness, courage, hope, and some real fun enter with her, the whole day is changed, and for old people and chronic invalids this means changing all that remains of an earthly lifetime.

It is usually taught in hospitals that a nurse should not intrude her own joys or sorrows upon her patients. For the public health nurse such advice requires modification. Her influence lies in her power to gain the confidence and affection of her patients. And who confides in or grows fond of an impersonal being who gives nothing of herself in return? Of course, it is not meant that a nurse should be foolishly unreserved about her own affairs, but a little of her delight at an approaching vacation can be shared with a patient who is capable of feeling an unselfish joy in her pleasure, or her own anxiety about an elderly mother may be so spoken of as to open the heart of an overworked daughter in a way that no mere effort to give comfort is capable of doing. For the same reason, though the personal acceptance of money by the nurses is universally prohibited by all good organizations, the little gifts sometimes made by loving hands are quite a different matter. The spirit that prompts these offerings would be killed by a refusal to accept them, and would bring an artificial element into what is a very sweet and simple relationship.

By a study of her patients a nurse may learn many ways of bringing pleasure into barren lives without taxing her time

unduly. One patient may be made to feel that she has really spent the hour of the nurse's visit at the moving picture show as she listens to the account of something the nurse has seen the night before; another may get a breath of the outside world through a description of the spring styles in the shop windows, or even by a graphic account of the nurse's vicissitudes in buying her own Easter bonnet. To others either of these things would seem frivolous, but a few moments forgetfulness of suffering may be obtained if they are encouraged to describe customs or conditions in their own far-away home countries.

A knowledge of human nature helps wonderfully. The nurse who planned a birthday party of three for a bedridden patient, added the most important touch of all, when, in addition to the beautifully frosted cake, gorgeous with name, date and candles, she carried a bag of lady fingers to eat with the ice-cream. What would have been the good of a wonderful cake that was merely eaten, and not displayed to the neighbors? What matter if, after two weeks of envied possession, it was almost too stale to cut when at last it was distributed to admiring friends? Through the rare joy of pride of possession, the pink candles and the nurse's thoughtfulness were the means of bringing a little light into a darkened life. Such seeming trifles should not be scorned, for no one without the experience of a long illness can realize the importance of trifles in a day that holds nothing else, except pain and weakness and anxious thoughts.

Convalescence is a time of great difficulty with the average patient, and here many otherwise good nurses, and we might add, good doctors, fail. As far as the economic value of the individual goes, he has none from the first day he is ill to the day of his return to a perfectly normal life, yet, half way through an illness, usually soon after the danger point has been passed, everyone seems to lose interest in his recovery. Sufficient attention is rarely paid to convalescence in hospital and private nursing, but in the poorer home the situation of the convalescent is often pitiable in the extreme, and some of the best work of a nurse may be done at this period of his illness.

The objective should always be the complete recovery, nervous and physical, of the patient, and his return in good condition to a normal life, and the nurse's work is no less valuable when it

is done through the medium of counsel and advice, rather than by personal ministration. Unfortunately most organizations have not the funds to permit carrying their cases when there is no longer need of bedside care or very positive instruction. Were it possible to continue oversight of convalescents for a more prolonged period, complete recovery would doubtless, in many instances, be hastened.

In procuring for her patients material assistance the nurse new to public health work will need to submit herself very strictly to the guidance of those under whom she works. An incalculable amount of harm can be done by unwise giving, and there are few public health nurses who have been long at work who cannot trace the downward path of some of their families to their own unwisdom in procuring for them material aid that they did not really need, and which they would have been far better without.

This brings us to the pay question. The fact is now generally accepted by the patients of all privately administered public health nursing organizations that while free care is given to those who cannot afford to pay for it, a fee is expected from those who can. As this fee is based on the financial situation of the patient it is obvious that there is no one except the nurse visiting the home who is capable of a decision in the matter, and there is usually no part of her work for which she is so little prepared. To a new nurse the decision regarding the ability to pay seems difficult, as does also an estimate of the amount that can properly be afforded, while the actual task of collecting the sum agreed upon often seems the most difficult of all. A little experience, however, will reveal the fact that such decisions are not a matter of trying guess-work, but are based on certain pieces of definite information quite easy to obtain. At present fees are not usually asked by public agencies, but on this point there is some difference of opinion, and a change of policy may perhaps be expected.

One weakness which is really a virtue carried to excess is to be found in some of the best nurses. The intense interest aroused by certain patients not infrequently so fills the mind of a tender-hearted nurse as to claim for them an undue proportion

of her time and attention, resulting in real injustice to others less appealing. Sometimes, too, the intensity of the interest burns itself out, and the very patient who has received in the beginning more than his due, ends by receiving less. It is steady, even, dependable care that produces the best results for the individual, and it is justly apportioned interest and devotion that produce the best results for the district as a whole.

In dealing with the doctors with whom she is brought in contact a nurse will have an opportunity to use her powers of adaptability to the full. She will meet very varied types of men, but to all she must accord a true loyalty. She will have her personal preferences, but such preferences must not be allowed to be felt by the patients, and an open mind will often discover ability where it is least looked for. In her relations with physicians, and also with other agencies, the nurse who informs herself of the rules governing what is known as professional etiquette, and then by a true spirit of cooperation tries not only to get help for her own work but gives her aid freely to the work of others seeking only the common end, cannot go far astray, for she will not fall into the fatal error of feeling that either unaided or unaiding she can be successful in furthering her cause.

The type of interest in her organization or bureau that makes a staff nurse thrifty and economical in the use of supplies, is important. A nurse should quickly reach the point when she so identifies herself with her organization that she will not be saving merely because she is told to be so, but because she realizes that a little wastefulness on the part of each nurse makes a big aggregate and reduces the organization's power of usefulness by just that amount, adding at the same time in equal ratio to the anxiety of those responsible for the financial situation. She may well put to herself the question, "If I myself gave a dollar to public health work, or if a dollar of the amount for which I am taxed were used for the purpose, would I be willing that it should be spent for gauze which is wasted, or in replacing articles needlessly lost or broken." The right use of donated or public funds is a responsibility that should be felt by the youngest nurse on the staff.

Because public health nursing is so absorbing many nurses defeat their own end by giving their entire selves to it, and by so doing allow other parts of their natures to become dwarfed and atrophied.

St. Vincent de Paul gave wise advice to Mlle. La Gras, who had charge of the first Sisters of Charity, "Be careful," he said, "of your health and be careful not to overdo. It is a trick of the devil by which he deceives good souls to entice them to do more than they can, and so make them unable to do anything at all." In these more modern days, living as public health nurses do, not in a sequestered community but in the midst of this rushing twentieth century world, it is difficult so to adjust one's life as not to succumb to this particular wile of the devil.

If the nurse is to see her work with a right perspective, she must see it through reading or lectures which will take her outside the four boundary lines of her district; and if she is to gain a like perspective for her life as a whole she must get away from her work altogether in her free time, that she may receive from people, books and places unconnected with it a glimpse of a larger horizon. Play, of the kind suited to each individual, is as necessary as food if good work is to be done, and should be planned for with as much care.

To the nurse with a healthy body and a nature kept fresh and sane by outside interests, the opportunities and privileges of the work are unbounded.

A laboring man who was heard to say, "I feel like standing with my hat off when a visiting nurse passes me in the street," not only expressed his own reverence for one nurse but the reverence which all who know the work intimately must feel for the opportunities implied by the uniform.

If the great body of staff nurses in this and other lands can meet their responsibilities efficiently, humbly and happily, giving to their organizations, public or private, a first-rate loyalty; to their directors and supervisors, a genuine effort to understand and assist them in the task of administration; to their colleagues, kindliness, and an effort to strengthen their hands; to the doctors and other workers not only a strict adherence to the rules of professional etiquette, but the touch beyond which will make

them more helpful; to the patients that loving care and intelligent sympathy so potent for changing stricken lives; and to the public health nursing movement as a whole a living interest—all will be well with public health nursing, for it will be builded upon a rock.

Chapter 3

THE SUPERVISOR

The position of supervisor is a comparatively new one in the history of public health nursing. In the very early days the nurses worked singly or in small groups under a superintendent of nurses. They were for the most part women of mature years and all alike were pioneers in a new field where precedence and previous experience played but little part. As the staffs of the city organizations increased in size, as younger women became public health nurses, as administrative decentralization became necessary, and most important of all as experience and experiment made possible a certain degree of standardization, a new type of worker became imperative. Also as the scope of public health nursing grew, other duties claimed the time and the attention of the superintendent, and even if this had not been so, the greatly increased number of patients would have made personal acquaintance with their individual needs and requirements impossible.

The first step in adjustment came with the placing of new nurses under those of riper experience who became responsible for their work. It was to be expected that under such an arrangement teaching and supervision would play an increasingly important part in the relationship of the two nurses, and that with this development the older nurses would find less and less time for their own work. The next step was a natural one. The able nurse, possessed of executive and administrative ability, who proved successful in teaching was soon wholly relieved of other work in order that she might give her entire time to supervising that of the younger nurses.

Two other factors have had their effect in the evolution of the supervising nurse. As the number of patients increased and the geographical areas to be covered widened, the big city organizations established branch stations in different localities,

placing a nurse in charge of each. These district heads were called supervisors. Also as such agencies as the Red Cross, the National Tuberculosis Association, the Metropolitan Life Insurance Company and the various state health departments placed nurses in the field to operate at long distances from headquarters, supervision of some kind became necessary, and the field supervisor came into existence.

At first the duties of a supervisor were rather narrowly confined to the instruction and supervision of the nurses placed under her. It soon became apparent, however, that in the supervising group of an organization lay a mine of first hand information regarding the actual health conditions of the community, and moreover that the individuals possessing this information were well qualified by training and experience to make a valuable constribution to their organizations in the form of constructive thinking. Today few organizations attempt to administer work or develop policy without the very definite assistance of their supervising group.

The duties of a supervisor therefore must be considered in their relation to a number of responsibilities; that toward the organization and the chief executive, that toward the nurses and that toward the patients. In addition the supervisor, like the director, finds herself involved in many community interests as well as in many interests affecting the public health nursing movement at large.

Supervision takes a number of forms, and supervisors are of various types. There is the district supervisor of a large organization working from a district headquarters where there are clerks, stenographers, volunteers and a special neighborhood committee, all, in short, of the make up of a small autonomous organization. There is the district supervisor of an organization where decentralization has not been carried so far and where all supervision is supplied from a common headquarters, each supervisor, however, being responsible for a certain prescribed territory. There is the single supervisor of a small organization who combines with her duties of supervisor those of assistant to the director. There is the specialist supervisor who is responsible for the development of some special line of work throughout the entire community, who may act as head nurse to a

group of specialized nurses, or who may work as consultant under a general system. There is the educational supervisor, responsible for the educational problems of her organization. There is also the field supervisor of an organization the activities of which cover a large territory and whose duties therefore involve continuous traveling. In addition to these there is the supervisor or head nurse who combines the supervision of other nurses with her own work in a district.

The question of how to secure satisfactory supervising nurses is a puzzling one for many organizations. The answer probably lies well below the surface, and has its roots in the debatable ground of general nursing education. Successful supervision implies a number of attributes in the supervisor by no means easy to secure in combination, and as it is impossible to wait for the evolution of the perfect woman a certain amount of compromise is necessary in every selection. There are, however, a few minimum requirements without which a supervisor can hardly hope to succeed. She must know general nursing procedure and also public health nursing procedure thoroughly, and she must have teaching ability and a desire to impart to others what she has already mastered herself. She must have a certain amount of administrative ability, and a genuine interest in the patients. She must be able to acquire the habit of thinking impersonally on organization problems, and she must have had the advantage of a sufficient amount of previous educational background to give her a personality that will make possible at least a moderate degree of leadership. This limited recital of essential attributes will seem to many too modest, but unless an organization sets itself very definitely to develop in each and every one of its staff nurses such qualities as careful attention to detail, the power to impart knowledge, and the ability to think impersonally, it will be unable to fill its supervisory positions from its own ranks, and will be obliged to import its leaders from elsewhere. This is always unfortunate, for though it is sometimes very desirable to bring new blood into an organization, it ought not to be too often necessary. The possibility of advancement is one of the best and most legitimate incentives to good work in any staff, and its withdrawal rarely fails to react badly on the general morale.

In private organizations the supervisors are usually appointed by the director, though in many, nomination at least is in the hands of the supervisory group itself. In others the supervisors elect nurses from the staff to their own body. On the whole the former method would seem the best, because in the long run it is unwise to relieve the director of so important a responsibility as that of appointment. It is one she should expect to carry, though she will undoubtedly depend greatly upon the supervisory group in making her decisions. In public organizations the form of government is apt to be less democratic, though there is perhaps an increasing tendency toward democracy. In no case should seniority alone determine appointment, though the record and personal qualifications of a senior nurse must be carefully scrutinized before she is rejected in favor of a more recent comer to the staff.

In meeting her obligations toward her organization and her director a newly appointed supervisor will find herself in a little different relation, both to those above her and those below her, from that with which she was familiar as a staff nurse. With her appointment she automatically assumes a share in the direction of policy, and to meet this responsibility she must accustom herself to think in broader terms than formerly.

At her early supervisors' meetings her opinion and point of view will be peculiarly valuable, because having so recently left the ranks she will still be in a position to know intimately the staff attitude of mind. She will quickly find, however, that she has a great deal to learn about a certain type of detached thinking that is required for the consideration of all larger issues. As she goes on she will probably find that her own personal preferences play a less and less important part in forming her opinions, and that gradually the general good of the organization and the welfare of the staff become the chief points of interest to her.

Supervisors' meetings must be taken seriously from the first, and a very definite contribution made to them by every supervisor. In all but the smallest organizations the director is necessarily more or less removed from the actual work of the staff, and unless important details are brought to her by the supervisors her decisions will be of little value. There are many

points of difficulty that are best elucidated by group discussion, and these should be brought to supervisors' meetings. If a supervisor is a specialist she will naturally be on the alert to insure in every discussion a due consideration of her special subject, and she will of course constantly place her own expert knowledge at the disposal of all. In addition to group consideration of the problems of a supervisor's district or service there will be many personal conferences with other supervisors. Much help for the work can be gained and given through such mutual interchange, and time should be made for interviews of this kind.

On a supervisor's personal relation to her director will largely depend her success or failure, for unless there is a common purpose and agreement regarding the general method of attaining this purpose, any satisfactory work is impossible. Above all, a supervisor owes her director frankness—frankness regarding the affairs of her district or service, frankness about her nurses, frankness of criticism. This obligation of frankness is not always quite understood by young supervisors, particularly in its relation to the individual nurses placed under their care, and sometimes a misplaced feeling of loyalty to a subordinate will prevent a report that should not be withheld. The successes and good work of a nurse are easily told, but a fear of tale-bearing or a mistaken idea of kindness will occasionally cause a supervisor to suppress unfavorable information, thereby practically nullifying all the value of supervision. The one supreme effort in this respect should be for honesty and justice through a faithful representation of facts, and a broad-minded analysis that will trace outward manifestations and actions back to the motives that underlie them. If a supervisor and a director are working in perfect harmony, everything is simplified, for to each problem will be brought not only the judgment of two different personalities, but the judgment of two individuals whose several positions give them a wholly different angle regarding any situation.

In supervising the work of her nurses, and in teaching and installing newcomers, a supervisor must have a system on which to depend and not rely on haphazard help and advice indiscriminately bestowed. Not only are positive instruction and demonstrative teaching necessary, but a means must be devised to

follow the progress of every nurse whereby definite continuous information regarding the work of each will be insured.

For these purposes the staff manual and the so-called "experience sheet" are helpful. The manual should be kept up to date and should contain definite instruction regarding methods of procedure and technique, the rules of the organization and such information as may be required regarding local agencies and situations. It should also briefly present the aims and purposes of the organization. The experience sheet is used for the new or student nurse to give a definite picture of the disposition of her time from the point of view of the educational value to her of the work she is doing.

Various methods may be used for instruction and supervision. Individual or group conferences, visits to the home with the nurses, review of daily report slips and a final review of closed cases in the light of the complete service rendered, working visits made to the patients by the supervisor on a nurse's afternoon off duty, and a routine inspection of bags to insure attention to this important factor in a patient's care. In some organizations a final visit is made by the supervisor after a case has been closed with a view to appraising the nurse's work on it. This may occasionally be desirable, but on the whole this method as a matter of routine is to be deprecated. It is exceedingly time-consuming where the service is active, and is apt to smack a trifle of the spy system. Efficiency reports, kept for each nurse and containing a running commentary on her progress, are extremely helpful in gauging the results of educative effort. Whatever the method of assignment of work may be, it is wise as early as possible to place the entire responsibility for given cases in the hands of a single nurse. At their conclusion the record will form an excellent basis for an analytical discussion of the causes of success or failure.

In her supervisory visits with the nurses a supervisor will naturally be careful to say nothing before the patient that will lessen the prestige of the nurse, or weaken the weight of her counsel. Demonstrations of technique given at headquarters will prepare the nurses for the routine part of a home visit, thus reducing the amount of instruction required in the home. Supervisory visits must be made pleasant to the patient and

his family, and no one allowed to look upon them as an intrusion. This is not difficult, for most patients consider a supervisor's visit a mark of attention and are glad to receive it.

Several theories are held in regard to the best method of assigning work. Some supervisors assign the work of each nurse every morning, feeling that only in this way is it possible to keep in touch with the various situations and insure prompt attention to the patients, and believing also that by this method each nurse can be so placed as to gain for her the type of experience desired. Others feel that by denying to the nurse all arrangement of her day's work, one of the best elements for the development of administrative ability is ignored. As a matter of fact every supervisor is obliged to consider many demands in the arrangement of her own work and her nurses' time, and in the rush of midwinter work there are few supervisors who are not obliged to make many concessions to the exigencies of an overburdened staff. They can but do their best, keeping always in mind the ideal toward which they are striving, but at the same time avoiding discouragement or any undeserved feeling of personal failure.

In addition to the actual teaching and supervision given to the nurses, one of the most important opportunities of a supervisor's life lies in her power to affect their attitude toward their work. If a supervisor loves her own work and brings to it the highest ideals of service, there are ninety-nine chances out of a hundred that her nurses will work in a like spirit. If she is imbued with a feeling of loyalty to the organization she serves, the loyalty of her nurses may quite assuredly be counted upon. If she works happily with the doctors of her district, appreciating at its true worth all that they are doing for the cause of health and for individual comfort and relief, her nurses will quickly develop the same sympathetic attitude of mind. Most important of all, if she has a feeling of intense personal interest for each individual patient and a sincere sympathy for his situation, her influence will be carried into every home visited by her nurses. Many supervisors regret the loss of their individual patients, feeling that their work has become less personal and therefore less inspiring. In reality the sphere of usefulness to the patients is greatly widened, for though a super-

visor may serve them vicariously, she serves them none the less truly, and through the greater number reached by her influence she is able to carry her service farther. If in receiving reports sympathetic feeling, gentleness, understanding, hopefulness and humor are encouraged, these qualities will most certainly be developed in the nurses. If on the other hand impatient judgment, ill nature, discouragement or lack of appreciation of suffering are permitted expression in the office or station, these feelings can never be kept wholly out of the homes.

The righteously indignant or justly irritated nurse needs a sympathizer, and often a backer, in her supervisor, but such help will best be given by an effort to raise the whole situation above the level of irritation and personal indignation.

Some patients and their families need a firm hand if they are really to be helped, and the child will be spoiled if the rod of discipline is withheld. The use of such a rod, though it may even entail the temporary withdrawal of the nurse, may be found the only means possible of dealing with some conditions, but it should be very carefully handled, and only wielded from the one motive of good in the long run for the patient. The dangers of the use of disciplinary measures are to be more feared for the nurses than for the patients, because of their slightly hardening effect on their mental attitude.

If a supervisor fits herself to see deep into the causes of the failures of the patients, she will be able to help her nurses to a point of view that will strengthen their powers of dealing with difficult and trying situations with wisdom and firmness, without in any way weakening the softer and gentler sides of their own natures. The demands of the poor are often unreasonable in the light of their poverty, but a little thought will show any impartial observer that what they want is what anyone would want under like conditions. If the nurses can be made to see this, that understanding will enable them to eliminate all seeming unkindness from inevitable refusal to accede to all a patient's wishes.

Every supervisor will recognize the necessity for the cultivation of a habit of character study, and will apply herself to the task of gaining an understanding of the various personalities assigned to her, for to be helpful she must have a

just estimate of the several powers and abilities of each nurse. She will quickly learn that the kind of stimulus needed by one is quite ineffective when applied to another. A word of encouragement brings all that is best in Miss A to the fore, while Miss B must be constantly though courteously reminded that she has not yet grasped all the principles or mastered all the procedure of public health nursing. Miss C's timidity needs reassurance. Miss D's progressiveness and tendency to free-lance work must be wisely curbed.

In her zeal for that most fascinating of all exercises, the management of people, a supervisor must guard against the temptation to have a mould of her own into which she tries to run the varying characters with which she comes in contact. She must have no mould at all, but must endeavor to help each nurse to help herself to her own best development. Tact and the right spirit will make the nurses look upon her as a friend and helper, and this relationship once established supervision becomes simple and natural, and the expression of well-considered criticism easy.

It is important that a supervisor should learn to work quietly and peacefully and that she should insist on quiet and peaceful work from her nurses. Everyone is familiar with that agitating type of individual who surrounds herself with a constant atmosphere of vibration. In her district there seems always to be trouble, or if not trouble something to cause excitement, and the general impression gained is of overwork, bustle and disturbance. In the district of a peaceful worker quiet prevails, and, though here as elsewhere, things go wrong, an atmosphere of tranquillity and leisure is never lost. It is not until these two types of workers change places that it becomes clear that the conditions of work may be identical, yet one will always be found in the midst of excitement, while the composure of the other is unaffected by outside conditions. When a supervisor is of the agitating type it has been found that no matter how popular she may be the nurses dislike to work under her, and a director who is looking for it can trace much of the nervous exhaustion of the staff to this particular quality in one placed over them. Because such a woman is apt to be possessed of mental and nervous alertness, and because her lack of tran-

quillity is often mistakenly attributed to efficiency and a love of progress, the serious drawbacks of this method of work are not always appreciated, and the contagion of agitation is allowed to spread throughout an entire staff.

The nurse thus inclined should be vigorously dealt with by her supervisor, and a quiet recital of her difficulties insisted upon in place of the excited accounts she prefers to give. If she is fortunate enough to possess a sense of humor, it can be brought to her aid in changing her mental attitude, for nothing is more amusing than the whirlwind entrance of such a nurse, her breathless account of the wrongdoing of everyone, and her final exit for a renewed dash to her district. Though laughable for once, such excitement is wearing in the extreme and cannot fail to react unfavorably on the patients, though they themselves would be at a loss to explain their increased nervousness after the nurse's visit.

Second only in importance to wise dealing with personality is the power to delegate responsibility. A supervising nurse cannot be, and she ought not to be, everywhere at once, but because she is not, there is no reason why anything should be less well done. She must not only know how to delegate her own responsibility, but she must teach the nurses working under her to in turn delegate theirs to some member of the patient's family capable of assuming it.

Miss Nightingale in her wonderful little book, "Notes on Nursing," with which, by the way, every nurse should be familiar, makes a number of pertinent remarks on this subject.

She says, "To be 'in charge' is certainly not only to carry out the proper measures yourself, but to see that everyone else does so, too; to see that no one either wilfully or ignorantly thwarts or prevents such measures. It is neither to do everything yourself or to appoint a number of people to each duty, but to insure that each does that duty to which he is appointed."

Miss Nightingale has little patience with any of the excuses usually offered by those who are weak in this power of giving over their work to others.

To quote again from the "Notes on Nursing," "People who are in charge often seem to have pride in feeling that they will be 'missed,' that no one can understand or carry on their ar-

rangements, their system, books, accounts, etc., but themselves. It seems to me that the pride is rather in carrying on a system in keeping stores, closets, books, accounts, etc., so that anybody can understand and carry them on, so that in case of absence or illness one can deliver everything up to others and know that all will go on as usual, and that one shall never be missed."

While these wise words apply to every type of leader, whether it be a woman managing her own well-ordered household or the head of some great business enterprise, they are particularly applicable to the public health nurse, the very nature of whose work implies her inability to be constantly with her patients. As we have said, what is done during the twenty-three hours that the nurse is not there, is quite as important as what takes place during the one hour of her visit. A lesson which has not been learned cannot be taught, so it must be the earnest effort of every supervisor to grasp thoroughly the fact that only by her own intelligent delegation of responsibility can a self-reliant set of nurses be trained, and the continuous good care of the patients assured.

Though the underlying principles of supervision are alike for all types of supervisors, there are many points of difference regarding details. The district supervisor who works from a local headquarters is responsible for considerable routine office work. This must be well systematized, for the nurses going out from an orderly systematic station are likely to carry order and system into the arrangement of their own work and into the plan of their individual visits to the patients. At the same time a supervisor must be careful to avoid an immersion in detail that will make of her an office worker instead of a supervisor of nurses. Records and written reports are necessary and valuable things, but the supervisor who places their importance so far above personal interviews and home visits with the nurses that she has no time for the latter has a wrong perspective. What a supervisor gives to a nurse of guidance, freshness of vision and breadth of view through home visiting, can be given in no other way.

Local headquarters should be happy, cheerful places toward which every staff nurse will turn her steps with pleasure. Some-

times lunches eaten together give an opportunity for a pleasant social hour and the valuable exchange of experiences.

Methods differ in regard to the time to be spent by the nurses at the stations, but it is usual for all record keeping to be done there during the hours of duty. In some organizations nurses report in person but once a day, in others twice or even three times. Where they report but once, telephonic communication takes the place of other visits. Round tables or group conferences held weekly are of help in reviewing local community conditions and in establishing habits of group thinking among the nurses.

Where neighborhood committees exist a district supervisor's relation to them is much the same as that of any director toward her board, except that certain matters of general policy must be referred to a higher tribunal of the organization. Neighborhood committees are still in a more or less experimental stage of development, and the pros and cons of the varying degrees of autonomy to be allowed them is a subject of much discussion. A supervisor must be so familiar with the general policy of her organization on all points that she will be in a position to help her committee to an understanding of them, while at the same time strengthening in every way the spirit of local responsibility that has brought the committee into being.

The supervisor who has no headquarters of her own but works from a central office will find it a little more difficult to establish close personal relations with her nurses, while the supervisor who combines work in the district with her supervisory duties has a quite different problem. For the latter a just apportionment of her time and interest will require careful thought and planning.

The specialist supervisor of a group of specialist nurses carries, in addition to the responsibility for the work of her group, a very definite responsibility for the development of her specialty in the community. In leading her nurses she will have to steer a straight course between a proper emphasis on the importance of their immediate work and a due appreciation of its subordinate relation to the whole broader problem of family health.

The specialist supervisor working under the generalized sys-

tem is at present in a pioneer stage of development, for as yet we have few precedents for her work. It seems probable that she will best act as a consultant, meeting the staff nurses at round table conferences, but otherwise dealing with them principally through their district supervisors. This method has many disadvantages, chief among them the fact that any advice regarding the conduct of individual cases will reach the staff nurse at second hand through her district supervisor, with a consequent loss of the specialist's own personal emphasis. Any other arrangement, however, has the even greater disadvantage of such a distribution of responsibility as can hardly fail to produce chaos for the nurse who is held responsible to three or four supervisors for the conduct of her district and the handling of her cases. The specialist consultant supervisor will undoubtedly blaze her own trail, and a few years will see the establishment of a recognized technique for her work.

An educational supervisor is held responsible for the training of new or student nurses. She arranges the schedule of theoretical work, giving herself such classes, lectures and demonstrations as are not otherwise provided for, and in cooperation with the field supervisors she secures suitable field instruction for her group. In this cooperative relationship to the district supervisors, an educational supervisor will require considerable wisdom and understanding, for though it is her duty to secure for her students the educational advantages that she thinks desirable, many concessions are necessary to the exigencies of the various situations, in the administration of an overbusy district. If all district supervisors could be imbued with an educational spirit and if time could be assured for the work required of them, the just demand of the pupils might be pressed. As it is, an educational supervisor must train herself to an understanding attitude of mind, remembering that one of her greatest assets to the organization is the effect of her point of view on the staff as a whole and particularly upon the supervising group, and that this influence will be lost if she is considered unreasonable or unsympathetic to the needs of the patients.

A field supervisor in an organization covering a wide territory works under the disadvantage of only occasional personal

contact with her nurses, and for this reason her technique of supervision differs somewhat from that of the supervisor who is constantly in touch with her staff. In addition to her visits in the field she will be obliged to establish a form of written communication that will give her a picture of field conditions and enable her to give suitable advice. She will also rely more on printed instruction than does the supervisor of a local organization. For her field visits she must acquire the habit of grasping general situations quickly and accurately. In this, experience will help greatly but she must be careful to avoid the temptation to generalize too broadly from a few previous experiences. Every situation is unique in some particular, and must be dealt with accordingly. In her visits to her nurses she may find cause to criticize, and criticism is an important duty. It is a good rule, however, to strike vigorously the note of hopefulness in order that a feeling of encouragement may be left behind. The effect of a supervisory visit that brings discouragement sometimes lasts for months, deadening enthusiasm, and casting uncertainty on every effort. In her short visits to a field nurse's territory, a supervisor must be careful to work through the local nurse, and not for her. It is easy enough for a seasoned executive to accomplish wonders of reorganization by the easy expedient of herself assuming the reins of authority and driving rapidly to the desired end. This method of rendering assistance rarely makes for permanent improvement, for on the departure of such a supervisor the local nurse is apt to find herself slightly discredited and her prestige a little lowered, while she herself is no nearer an understanding of how to deal with difficult situations than before. Slower processes, achieved by the nurse herself on the advice of a supervisor, will be more successful in securing permanent results.

A travelling position is a hard one physically, and a field supervisor must take careful account of her health, saving it wherever possible and trying to lead as normal a life as the conditions of constant travel will permit.

All supervisors except those who work in a consultant capacity are held responsible for the health of their nurses, and this duty is an important one. The term "preventive sick leave" has recently been coined to describe an old expedient to keep a staff

in good condition physically. It means those few days of rest allowed to the over-tired nurse *before* she succumbs to illness. If an allowance of preventive sick leave is, as it ought to be, the policy of an organization, its right application requires considerable wisdom and discernment on the part of a supervisor. Nurses vary as greatly in their physical make-up, as in all other respects. There is a minimum physical standard below which an organization cannot afford to go in its acceptance of nurses for the staff. Above this minimum excellent women may be taken, capable of fine work, who nevertheless will fail to reach a maximum of physical fitness. Too little discrimination and individualization is frequently shown in dealing with such nurses, and exactly the same requirements are made of them as of those of greater physical capacity.

It is an easy matter to divide a staff into those that are sick and those that are well, and to provide nursing care for the sick and plenty of hard work for the well. We are long past any such crude conception of health for the community at large, and it is certainly logical that a staff of nurses should receive the same individualized consideration that they are giving to others. Physical examinations by prescribed doctors before acceptance on the staff, repeated annually, should be a matter of routine, and in addition every supervisor must make it a business to know as much about the physical equipment of her nurses as she knows about their mental equipment or their moral equipment.

A very considerable portion of every supervisor's time will be spent in what is known as "making contacts," or coming in touch with the many men and women, professional and otherwise, whose various fields of activity are related to that of her nurses. These contacts are of great importance and should receive thoughtful attention. Some of them may be wisely delegated to the nurses themselves. Others must be made by the supervisor. In these various relationships an appreciation of the value of cooperation is necessary, and also a large amount of plain common sense, applied with what New Englanders call "pleasantness." Without pleasantness the sterner virtues do not always find favor. With it even common sense becomes agreeable.

It is generally conceded that to see the other man's point of view is the secret of cooperation, but in the course of daily work the ability to make him see yours is certainly not of less importance. The greatest successes which the public health nurses have gained have been won by the exercise of this power. Sometimes such understanding is brought about by personal interviews and careful explanations; sometimes, and this has been the case with many doctors of the less progressive type, by patience and quality of work that in time wins confidence. It is inevitable that to a work which by its very nature involves the effort to lead in new paths, such understanding should not always be accorded. When it is not, no bitterness must be allowed to creep in, but the work should be continued with courage and independence. If a rock impossible to climb over is in the way, no false pride must prevent a circuitous route around it.

It is not too much to say, however, that at least a good proportion of the cooperative woes under which public health nurses groan are those of their own making, and could be avoided by a little more tolerance and understanding, a little more patience and effort to see the other person's point of view, a good deal more time given to explanation, and a cultivation of that aforementioned pleasantness, the lubricator of so many creaking wheels. It is only when all these have been tried to the uttermost that a nurse may have the honor of donning the martyr's robe and joining with cheerfulness and hopefulness the great army of those who have been permitted to suffer for a cause they love.

Supervision has passed out of the pioneer period of its development. It is not a luxury and mere elaboration of public health nursing routine; it is a vital necessity to the present system of organization, and no community should be allowed to underestimate its importance and value. The proper ratio of nurses to supervisors is still, however, a mooted point. Dr. C.-E. A. Winslow suggests as a minimum a supervisor for each ten nurses. By some this estimate is considered too low; and these would allow one supervisor to six nurses. It is generally conceded that a greater number of supervisors are required under the generalized than under the specialized system.

Chapter 4

THE CHIEF EXECUTIVE

The duties and responsibilities of a director or superintendent of public health nursing depend upon the type of organization of which she acts as chief executive.

A director of a large organization in a big city spends a considerable proportion of her time in committee work, in conferences and in the consideration of questions of policy, leaving to subordinates much of the detail of actual administration. A director of a small organization has no such staff of subordinates and must herself deal with many questions of detail. Directors of privately administered agencies are responsible to a board of managers, their relationship to which is of the greatest importance. Directors of publicly administered work on the other hand are usually directly responsible to some superior officer, and in many instances there is no nursing committee at all. In addition the duties of a director of a specialized agency differ somewhat from those of a director of an organization doing all types of public health nursing. The very titles employed to designate the position are descriptive of the differences implied. Many of the older visiting nurse associations still use the term superintendent of nurses, others employ the newer one of director, a title that is more truly descriptive of the duties of the office. Public agencies use both titles, and also that of chief nurse.[1]

In spite, however, of many points of difference there are certain responsibilities and relationships that all directors have in common. These may be divided into five groups:—*First,* her responsibility toward her board of managers or the superior officer on whose final authority she must rely; *second,* her responsibility toward the nurses whose well-being and efficiency

[1] The title of director is here used to designate the chief executive of all types of public health nursing organizations.

lie in her hands; *third,* her responsibility toward the patients for whom the whole organization is primarily existent; *fourth,* her responsibility toward the community which has a right to expect from her expert knowledge on her own subject and such a spirit of helpfulness and cooperation as will further every good work; and *fifth,* her responsibility toward that larger world of public health nursing which lies beyond her immediate field of action, but to which she must make constant contribution if the public health nursing movement is to go forward in future as it has in the past.

The success of a director lies in the skill with which she fulfils these obligations, allowing no one to be met at the expense of the others but maintaining that desirable balance which will strengthen all.

In private organizations the first of these responsibilities, that toward her board of managers, is one of great importance and it is also one in which many otherwise excellent directors fail. This is not surprising because there has as a rule been little in the previous training of a nurse to fit her for this particular duty. If she is a beginner she is inclined to err in one of two exactly opposite directions: either she underrates the importance of a board of "merely lay" people, taking as a standard of value those things which she herself as a professional woman knows better than they; or she allows herself to become a mere servant of the board, failing to place at their disposal the knowledge and experience which she possesses in fuller degree than they.

The nurse who is inclined to the former tendency should not forget that she is transitory while her board is permanent, not of course as regards individual membership but as a governing body, and she must learn to value at its true worth the point of view of men and women who are, perhaps, authorities on other subjects, and who from the very fact of their relative remoteness from the problems involved bring to them a freshness of vision which may be denied the harassed nurse impatient for immediate relief. In her desire for sympathetic understanding she must remember that it is through her only that the members of her board can feel as vital realities these things which she describes.

Nine times out of ten if she finds her board unsympathetic

or lacking in enthusiasm it is because she herself has been unsuccessful in presenting the work to them in such a way as to awaken either their sympathy or their interest. Let her for a moment thoughtfully put herself in the place of the members of the board. Let her be denied all direct contact with the patients, all intercourse with the nurses, all the creative joys of administration, and give her instead the anxious task of money raising, and the impersonal duty of legislation, and where would her own sympathy and enthusiasm be?

In planning monthly board meetings the special predilections of a board must be taken into account. It will usually be found that meetings attended exclusively by women can, with advantage, be made longer and more informal than those at which men are present. Women are more interested in detail, and make their best decisions if very fully informed in regard to them. Men are teased and confused by over-explanation and are apt to grow restive if they are detained beyond an hour's time. When her board is composed of both men and women a director is confronted with a rather difficult problem in trying to meet the wishes of all. A certain amount of experience is required to make a report that is interesting and informing and at the same time brief. This nevertheless can be done. Written reports are apt to be more carefully prepared than those delivered orally, but they are on the whole less interesting. An oral report, however, requires quite as much time and thought for its preparation as a written one. A folder, kept throughout the month, will be found helpful, into which can be slipped items of interest from which notes for the meeting may be made.

A monthly report should contain first of all a few statistics. These will never be anything but unintelligible to the average member of any board if they are read without comment. The information that one thousand six hundred and twenty-three patients have been cared for, or six thousand one hundred and ninety-two visits made, means nothing to anyone; but these figures assume significance if it is pointed out that in the previous year during the same month the number of patients was a hundred less, or that the additions to the staff have made possible a relatively larger number of visits per patient. Also a few words of analysis as to the type of case cared for is help-

ful. The fact that the number of obstetrical cases is increasing in certain districts of the city or that it is the season when much time must be given to the exacting care of pneumonia, will prove interesting. Relative statistics obtained from the city hall records as to cases of tuberculosis reported, or the infant death rate compared with statistics of previous years or of other organizations doing similar work, will make the dry figures live. Anything which will accomplish this end is desirable, for on the deductions that may be drawn ought to depend much of the legislative action of the board. All this will be simple if the staff of the organization includes a trained registrar whose work it is to furnish such information in tabulated form. Many governmental bodies have excellent statistical departments, but only the larger private organizations can afford the services of a trained statistician. In the absence of such assistance a director must learn to put her own brains to work, for there is no excuse for vagueness of knowledge on so important a subject as the statistical results of the work.

In giving her report a certain amount of time should be spent on the current happenings of the month. Serious difficulties should be frankly stated, but if on the other hand pleasant things have occurred the board should have the advantage of hearing them. A director sometimes goes on the principle that because some part of the work is going well, no mention of it need be made. The result is that the hour of the board meeting is invariably spent in the consideration of woes, and the members go away with the mournful impression that the workers are always in trouble, and that public health nursing is a very difficult proposition indeed.

This may be avoided if an effort is made to strike an optimistic note in the presentation even of difficulties, and by so balancing the items reported as to have something of a cheering nature to offset discouraging information.

Because of the necessity of attending to important matters of policy, there is a temptation to omit all mention of individual patients or stories connected with them. This is perhaps unfortunate, for with certain people the simple tale of one dying baby which has been saved is far more effective in arousing a desire to help than the most painstakingly accurate

data regarding a fall in the infant death rate. Often these stories are best told by one of the staff nurses, for the use of the personal pronoun in the telling makes them seem more real and vivid, and the presence of the nurse herself will stimulate helpful questioning. It goes without saying that names should never be used in telling these stories, even where it would seem quite safe to do so, for the right of the patients to privacy concerning their own affairs must be rigidly respected.

Though it is unwise to trouble the board with partially made plans or undigested ideas, it is wise for the director to keep the members quite closely informed of her hopes and aspirations for future development. Frequently a cherished project which has been simmering in her brain for a year or more will suddenly be presented to the board, and to her chagrin and disappointment it will be voted down, against her urgent advice. Had it been allowed to simmer in the brains of the managers for the same length of time a different verdict might have been given. A statement that though the time is not yet ripe, sooner or later the board may be asked to consider a certain project, or the description of a like venture elsewhere, will often pave the way for a more serious consideration of the matter later on.

One universal principle may be laid down, namely, that no director must try to move more rapidly than her board of managers, for behind every action she must have the approval, not merely the antagonistic acquiescence, of her governing body. If she fails to gain this on matters of importance, she should take counsel of herself and decide whether she had best pursue a course of hopeful patience where she is, or seek a position under a board whose aims and methods more nearly correspond with her own. Before coming to the latter conclusion she will of course try to make sure that her demands are not only reasonable in themselves, but reasonable in view of the local traditions and prejudices with which her board may be better acquainted than she is herself. On the one hand lies the danger of too hastily relinquishing a valuable opportunity for usefulness, and on the other the possible good which sometimes comes from the dignified retirement of a nurse whose just demands have not been acceded to.

In any event perfect loyalty must be accorded the board,

and in case of resignation a quiet unemotional statement of the reasons for going should take the place of heated argument or recrimination. Nor should too great discouragement be felt by a director thus retiring. All history shows that it is rarely the advance guard that carries the citadel. To change the metaphor, it is on the foundation of the apparently utter failure of some of the finest men and women the world has ever seen that have been built most of the noblest structures of progress. No woman should feel herself unduly a martyr if with the best intentions and highest ideals she fails to carry her points. Rather she must study her own failure in the light of what history the public health nursing movement furnishes, to see if with a deeper understanding of cause and effect it might not have been possible to avoid some, at least, of the pitfalls into which she has fallen.

Of the five responsibilities we have mentioned that toward the board of managers requires, perhaps, the most thoughtful and vigorous effort. No part of this duty may be delegated to others, and both wisdom and creative ability are required in no small measure. Half the failures, however, to make the most of the unique opportunity to interpret managers to nurses and nurses to managers, and to make the work seem alive to a body of people not in direct touch with it, arise, not from a lack of ability, but because this part of a director's work is not taken seriously. Too often the managers' meetings are looked upon as necessary, but unfortunate, interruptions to more important duties, and the director's contribution to them consists in a conscientiously exact, but deadly dull, enumeration of statistics and the gloomy statement that everyone is overworked, or that the board of health is very trying. The unfairness of accepting as an unchangeable fiat of the gods, decisions made by the board founded upon the insufficient information that she herself has furnished them, does not occur to such a director; and when these decisions prove unwise blame is placed on quite the wrong shoulders.

To sum up on this point we might say that a board of managers has a right to expect of its director an intelligent effort to understand its point of view, a wise leadership, sound administrative methods, a fearless statement of the nurses' needs and

requirements, and such carefully prepared reports of the work as will put them in intimate touch with all that is necessary in the way of general tendencies and detail, and will constantly stimulate their interest and arouse their enthusiasm. In addition they may rightly expect to be kept informed through her of such important developments in public health nursing as may be taking place elsewhere, in order that a wider horizon may give perspective to nearer details.

In publicly administered work a director has no board of managers, but she may have a nursing committee that is in some respects similar, though as a rule it differs in one fundamental point. It usually acts in an advisory capacity, having no executive powers. It is not therefore a governing body as is a board of managers, and she has other authorities to consider in planning policies, or arranging her work. Her relationship to such a committee, however, is much the same as that of any director of a private organization to her board, and she must make the same effort to arrive at a common point of view and give equal thought to preparation for the meetings.

In her relation to the medical director, or whoever her superior officer may be, the personal equation necessarily plays an important part. He may be a man whose ideals, modes of thought and plan of work are identical with her own, in which case her path will be an easy one. He may, on the other hand, have an entirely different point of view, and she may feel hampered both in handling her nurses and in carrying out her plan of work. Under these circumstances infinite patience is required.

There are few men and women, however, so set in their opinions that they never change, and a nurse new to a public position must frequently remind herself that she has a great deal to learn about publicly administered work. She is far more of a cog in the wheel of a big piece of machinery than is the director of a private agency, her place and field of activity are of necessity more clearly defined, and her relationship to other departments makes a too free initiative impossible. In dealing with those in authority over her it is well to remember that without loyalty no form of organization is strong, but that loyalty does not mean a weak subserviency to another point of view. An opinion frankly and courteously expressed, without

emotion or ill nature, is often effective provided always that there is a fair give-and-take in the matter.

The *second* responsibility of a director, that toward the nurses, is more tangible and simple than the first, and therefore somewhat easier to meet. While the power of leadership in its essence may be looked upon as a gift from heaven, like that bestowed upon the artist, the poet, or the musician, a few simple ingredients go into the making of a leader, and may be cultivated to advantage by all whose duties include the management and control of others.

The first necessary attribute is justice, and without this all the other more agreeable qualities are almost valueless; a second is the power to see the work as a whole in which all the different parts are proportionately valued; a third is the orderliness of method which usually goes under the name of executive ability; and a fourth, almost necessarily included in the third, is the power to delegate responsibility. Through all these qualities must run the golden thread of sympathy, the quality which has the power to raise all work from the mere level of required duty up to the heights of joyous service.

The director of a private organization has a free hand in the selection of her nurses, but this is not always the case with governmental bodies. Under the civil service system a director of a publicly administered work may have considerable latitude in making her selection from the civil service list, but on the other hand she may have little or no initiative in the matter, being obliged to take the first nurse on the list for a trial period covering a number of months. Under these circumstances, if civil service requirements are low, it is difficult to maintain an efficient staff, but civil service commissions are by no means impervious to education on nursing matters, and with the help of her nursing committee a director can sometimes bring about a change in the requirements that will secure higher standards. Freedom in the choice of nurses undoubtedly simplifies the work of a director but even under the most favorable conditions selection is not always easy. The apt, if inelegant, statement of King Henry the Eighth as to the impossibility of making a silk purse out of undesirable material contains a real truth, and a director will find that unless she can attract to her organiza-

tion nurses of a certain fine calibre, she will never be able to maintain the standard she desires. All types of women apply for public health nursing positions. They include the finest type, to whom the opportunities and nature of the work appeal, and the poorest type, who have been failures at other kinds of work, or to whom the free evenings and an assured salary form the sole reasons for application. Between these two extremes are innumerable varieties which finally merge in the average specimen who is capable of improvement under favorable conditions, or of equal deterioration under those that are unfavorable.

Just in so far as a director is able to gather her staff from the type of nurse above the average, or to raise them to a higher level after acceptance, will her own duties and responsibilities be simplified, and her ends assured. A good system for obtaining and filing information regarding applicants for positions is essential. Intuitive knowledge of people is given by nature to some favored few, but a careful study of character, based on what might be called observation of symptoms, will develop such knowledge in those to whom the natural gift has been denied.

In accepting new nurses it is desirable to fill the ranks with those who will later have the ability to rise to higher positions. If this, however, were made an absolute rule, many really excellent and much beloved nurses would be obliged to leave the field of public health work. Executive ability can sometimes be dispensed with in subordinate positions on large staffs, and a woman possessing nursing ability and the qualities of gentleness, cheerfulness, conscientiousness and absolute devotion, qualities so dear to the hearts of the patients, may be saved to the work.

Quite as much skill may be exercised in the placing of nurses as in either their selection or training, for if it is impossible to make a silk purse out of the inferior material of a sow's ear, it is quite as impossible to make one out of a material equal in value, but of different texture. A vast injustice is not infrequently done to a valuable woman by placing her in a position requiring qualities she does not possess and cannot acquire and then judging her entire ability by her inevitable failure in this capacity.

A preconceived idea of what people ought to do, based on a principle that takes no heed of individual character and individual prejudices or weaknesses, is responsible for many avoidable failures; and the truth, so often reiterated, that no woman works happily unless given opportunity for the development of her own personal powers, applies to every nurse on the staff, though range for free initiative must necessarily be different under different conditions.

Owing to the militaristic traditions of hospital training there is still danger of autocracy, though the day has long passed when a director is satisfied with a staff of obedient children content to do her will. The best security from the danger of an autocratic rule lies in the development of a body of women who will think for themselves, and whose ideas and theories are so valued that they become a part of the very warp and woof of the organization. In this way only will *esprit de corps* be developed, and in this way only will united strength be achieved. If these ends are gained, a director may well feel that she can sing her *nunc dimittis,* for the welfare of the organization will not rest on any ephemeral advantages, nor on the personality of any single individual, but will be secure in the united strength of all its workers. Such a spirit will be contagious enough to infect new comers, and in spite of a possibly changing staff old traditions will be carried on, and thus assure the best elements of permanency in the work.

Difficulties will arise, for public health nurses, despite the poems extolling their angelic qualities, are of very human material, and are quite as capable of being exasperated with each other as are any other groups of people. A little judicious manipulation of positions, and a resolute determination to prevent the insidious creeping in of an antagonistic spirit, is usually sufficient to secure harmony. If not, it is better to part with a valued nurse or pair of nurses than to allow the development within the organization of opposing factions that would in time undermine the whole structure.

The nurses' health is always a matter of anxiety to a director, for the work is hard and the exposure to weather great. A rule obliging the nurses to report minor illnesses at once should be strictly enforced, and often a day or two of rest, or even a

slight lessening of the strain, will prove all that is required. All of the nurses should be carefully watched and it will be found that for many eleven months of unremitting work is not possible. An extra half day, or a morning off duty in which to "sleep over," or even a few shortened working days administered at just the right time, may often save a longer sick leave. There is little danger of public health nurses becoming softened, for the exigencies of their work would seem a sufficient safeguard against softness in any form, and health is too precious a possession to be lightly jeopardized.

With a large staff much of the oversight of the nurses must be left to others, but free access should always be possible to the director herself, and every encouragement given to the discussion of difficulties.

If a director has been successful in gaining the confidence and affection of her nurses, and if she is given to managing, she may be confronted with the temptation to exercise a somewhat despotic control over their affairs. She must draw a very sharp line between their personal concerns, over which she should exercise absolutely no control whatever in any detail, and the affairs of the organization, which are of course rightly her responsibility. If her advice is sought she will naturally give it as would any other sympathetic friend, but such advice must not be allowed to assume the form of a command. Only when the nurses' personal affairs affect their work or their influence in the association, do they become the responsibility of the director. Paternalism, with all its good points, has its grave disadvantages, and if applied to a group of nurses will not in the long run make for the general happiness.

The *third* responsibility, that toward the patients, is one to which it is easiest for a director to respond, and the one to which it is least necessary that she should do so. Do not let us be misunderstood, or seem to underrate the importance of the patient. This book will have been written in vain if it fails to emphasize, first and last and all the way through, the fact that it is for the patient that all else exists. A director does her work for the patients vicariously, however, though she may often wish that it were otherwise, and it is upon her power to place this responsibility in other hands that the successful work of

the organization depends. A good director early learns to delegate both responsibility and actual work, and to spend the time thus saved in the selection and training of those who are to assume these functions. If a method of supervision has not been devised by which the supervisors and nurses can do this without undue appeal to an already overtaxed director, then the whole plan of administration is weak, and a director thus deflected must apply herself to strengthening her staff, and to obtaining for them some better system of supervision. We are not of course speaking of the executive of a small organization whose legitimate responsibility just such detail and supervision may be, but of the director of a large staff, who, because of a countless number of unnecessary distractions can never be found at leisure to talk over a matter of policy with a puzzled nurse, or to attend to the more important duties of her position. It is to be regretted that few directors find time to do any home visiting with the staff nurses. Where this is occasionally possible it tends to keep a director's own sympathy and enthusiasm fresh and spontaneous, and the danger of guiding the work from an office-chair point of view is avoided. Beyond this the welfare of the patients must be dependent, not on the director's personal knowledge of their needs, but on her ability to choose the right nurses, and to keep alight within them the divine fire of sympathy combined with the highest standards of efficiency.

The *fourth* responsibility, the duty of a director toward her local community, is more complex than those already spoken of. Just in so far as her own work has been successful will she be called upon for participation in the various affairs of community interest. Public health nursing, touching as it does the home life of the people, is so closely cooperative with other activities that it is almost imperative that her organization, whether large or small, public or private, be represented at all councils dealing with questions of community betterment. Nor can she be a mere follower in these matters. She must expect to take a leading part in community health work, furthering the activities of others and gaining for her own work that type of intelligent understanding that is the result of worthy representation.

Here again excellent results can be obtained by a wise dele-

gation of some of these outside responsibilities. Members of the board, or other nurses, may be called upon both for committee work and the public speaking that is sure to be asked for. In regard to the latter, it is hard for many nurses, who have had no experience in public speaking, to accept the fact that it is really a part of their work. They might as well, however, accept it first as last, and try to do it as well as possible. Someone has tried to encourage the timid speaker by saying that to achieve success he has but to observe three simple rules,—to stand up, to speak up, and to shut up. Only the shy can appreciate the agony of spirit implied in obedience to the first rule, but many a wearied audience can testify to the number of untrained speakers who do not know how to make themselves heard or when to stop. Half an hour is plenty of time for the average talk, and is longer than is accorded to many ministers for their Sunday sermons. Practice, and care in preparation of notes, together with a firm determination to follow the third injunction we have spoken of, will reduce the time required for saying what has to be said interestingly, and if all attempts at oratory give way to the desire to make the work known to the audience, this much hated task will become less irksome.

One duty to the community should be performed by the director herself whenever possible, and that is listening to complaints. If every one with a grievance is made to feel that he has done the good deed that he really has by bringing it to headquarters, much of the petty discomfort growing out of misinformation can be avoided, and real troubles dealt with, with dignity and fairmindedness.

Time spent in explanations is time well spent, from the hour given to trying to make Giuseppi understand in the simplest English that it is highly improbable that Miss Smith, the most trustworthy nurse on the staff, has stolen the quarter of a dollar which Mrs. Giuseppi asserts was missing from beside the clock after her call, to the still longer interview during which Mrs. Van Blank is allowed to give all her reasons why her special protégé is like no other patient, and should therefore receive a daily evening call. The greatest asset an organization has is the good-will of the community, and if Giuseppi and his

friends can be made to feel that it represents honesty and helpfulness, and if Mrs. Van Blank and her friends can understand that necessary rules do not interfere with kindliness and sympathy, these hours have been spent to the best possible advantage.

The *fifth* and last responsibility, that of furthering the cause of public health nursing beyond the boundaries of her own immediate community, is one that is forced on every director early in her career. As she proves successful in her own local field she will find herself in demand, first, for state or county work, and later for the national or international field. These demands most often take the form of requests for committee work, or the holding of office in state, county or national associations. We have no wish to make of any director a second Mrs. Jellyby who will expend her energies on Borriobbola Gha, while the affairs of her own organization go like the little Jellybys to rack and ruin. It has long been plain, however, that all local work is exceedingly dependent on those state and national bodies which advance and maintain standards and act as clearing houses for general information, and if such organizations are to be maintained it is evident that a certain amount of responsibility for them must be carried by the representatives of local agencies. The best organizations, both public and private, are generous with their executive's time for such work, realizing that not only is the broader field served in this way but that much good reverts to them directly in the increased knowledge and broader development of their own director.

Interwoven with these many duties and activities of a director should be a normal life of family relationships, friendships and social intercourse, and about the latter a few words must be said. Many nurses in undertaking strenuous work feel that they are called upon to sacrifice to it all those ordinary social relationships that do not involve close friendship or actual demand. Wholly apart from the nurse herself this is a mistake from the point of view of the organization. There has been altogether too much isolation about nursing, and because of this isolation, altogether too little understanding of the problems, interests and objectives of nursing work. The institutional executive, owing largely to her life in the hospital, has found it difficult to

keep up an outside social life. The public health executive is differently situated, and should make it a point to mingle somewhat at least in the social life of her community, not necessarily primarily for her own pleasure—she may even dislike it—but for the sake of her work. College deans and presidents, who are certainly busy women, find this possible and indirectly do much in this way to foster intelligent understanding of the aims of their colleges. The director who systematically refuses all social invitations because she has not time to accept them has yet to emerge from a method of working that is keeping women from attaining their highest usefulness in the more important fields of labor.

After this enumeration of the manifold duties of a director it may seem asking the impossible if we adjure her not to overdo. That, however, must be the closing word on the subject, for wise apportionment of her time is after all merely a question of selection. If she is to be a good executive, bearing a right relationship to her board of managers and taking time to prepare for their meetings; if she is to know personally her nurses, selecting and guiding them thoughtfully; if she is to take her proper place in the community, keeping herself accessible to those whom she may help; if she is to do her share of state and national work, it is obvious that she must be relieved of other less necessary duties. Nor is it enough that all these activities should be fitted into her life like the pieces of a picture puzzle. The director of a progressive organization, if she is a wise woman, will frequently take time for meditation on the subject of her duties; for if she is to retain her peace of mind, elimination must not be left to accident but must be the result of a careful program. If she can keep her tranquillity and do her work with one month's vacation, well and good; but, owing to the demanding nature of the duties, few can accomplish this. If she becomes fagged and discouraged by the multiplicity of her responsibilities, her organization will buy back her enthusiasm and courage cheaply with a few days leave of absence as often as her particular physical and nervous make-up may require it.

In weighing the various demands made upon her she must

let no shortsighted spirit of self-sacrifice cause her to use herself up in the earlier years of her usefulness, lest in those more valuable years which come later in life the knowledge and experience which she has gained at so much cost may be unavailable, because of physical disability.

Chapter 5

GROUP MANAGEMENT

An opinion prevails that the power of leadership is a divine gift, and that nothing therefore remains for those to whom this has been denied but to make the best of a bad situation.

Certainly the power to lead, control and inspire groups of men and women is a gift possessed in varying degrees by different people. To some it comes easily and without apparent effort, to others it does not seem to come at all, as more than one poor, mismanaged staff can testify. The rank and file of men and women upon whom leadership is thrust may, however, acquire a certain technique which will prevent the worst mistakes and which will at least secure a working plan.

The first requisites are a desire to learn and an appreciation that there is much to be learned. A nurse who fully appreciates that study and hard work are required if she is to attain ordinary proficiency in nursing technique, will often light-heartedly undertake the difficult task of staff management, taking it for granted that she will "get along" and that in some miraculous way this particular kind of proficiency will be attained without effort. Her failure to secure a happy atmosphere or to acquire or retain efficient nurses she puts down to conditions quite beyond her control, oftenest to what she considers the unfortunate personalities of those with whom she is forced to work. It is true that some people are hard to work with; but this is not true of all people, and a difficult staff is usually a staff which is poorly led.

Little time need be spent on the careless, stupid or uninterested leader. She may be dismissed with the statement that unless she can become careful, intelligent and interested she would better resign from leadership without delay. Failure, however, is not confined to the incapable or wilfully careless. Many well-intentioned women fail utterly, for mere good in-

tentions prove disappointingly illusive when it comes to the practical details of administration. Unless a leader is very obtuse she is apt to be uncomfortably conscious of an atmosphere of criticism, but she does not always try to analyze the symptoms which cause her discomfort. Few nurses tell their directors what it is they dislike about her or her administration. In many instances they are not very clear themselves, but experienced leadership implies a quick appreciation of every symptom of distress and sound diagnosis of the cause.

It may not be amiss to step for a moment behind the scenes to listen to the comments of a dissatisfied staff. A list of ten such comments taken at random might read as follows:

1. "I never know where I am, the boundary line between my work and that of the other nurses is so indefinite."
2. "My work is not well planned, but I am not allowed to plan it myself." Or, quite as often, "The plan is good but I hate working that way."
3. "When I want to make changes to which I have given careful thought, I am told they are impossible. Perhaps they are but I am given no satisfactory reason."
4. "Miss Blank is so inaccessible, or when I do see her she has so little time that I cannot make her understand what I mean."
5. "All Miss Blank's time and interest are given to Miss S."
6. "Miss Blank is very nice but I don't know her."
7. "Whenever I talk to Miss Blank I always seem to be put on the defensive."
8. "I feel as if Miss Blank looked on me not as a human being, but as a machine to do the work."
9. "I am getting nowhere here, there is no future and I never feel part of a whole."
10. "I am not sure that Miss Blank will pass on a good opportunity to me because I have become useful to her here."

These are not the mere grumblings of a discontented group of young people. Much constructive criticism is here for the woman who knows how to use it, and all these suggested conditions are easily remedied if correctly diagnosed. The first and second comments suggest poor organization, though the second objector is also putting in a not unjust plea for individualization. Possibly number three's contribution is valueless, on the other hand it may not be, and in any event she should be

made to feel that all constructive suggestion is welcome. Four, five and six suggest unwise apportionment of the director's time, number seven and eight a lack of sympathy and understanding, nine a failure to give vision or coordination to the work, and ten a real unfairness, which is none the less unfair because the motive is probably the welfare of the work rather than a personal one.

A list of such criticisms could be lengthened indefinitely. Time has been spent on these examples, not because of the specific questions raised by them, but to illustrate how all criticism can be used constructively. Like the beggar on the street, the staff nurse who criticizes her director may not need the thing she desires; but criticism, like begging, denotes a wrong situation of some sort which demands study and readjustment.

The leader of a group of public health nurses should occasionally take time to ask herself what, after all, she is trying to do. Reduced to very simple terms, she is probably trying to secure from her nurses the right kind of work, and for her nurses the right conditions under which to do this work. In addition she is presumably also trying to develop the best that is in each nurse for three reasons, for the sake of the nurse herself, for the sake of the immediate work, and for the sake of the public health nursing field at large.

To attain these ends a director must have a form of organization which is workable, for creaking organization wheels are the source of much trouble. Nurses are sometimes added to a staff without due consideration of their place in the organization plan, with a resultant confusion regarding their duties and responsibilities. The first necessity therefore is a plan of organization which will meet the need, and which will be logical enough to be easily diagrammed and made clear to the nurses. Every member of the staff should understand to whom she is directly responsible, and exactly to what extent she is responsible for the work of other people. All delegated authority must be sharply defined, and all duties and prerogatives made plain. In large organizations details may be set forth in an office manual, which, by the way, is better multigraphed than printed, to simplify revision.

A common mistake in many organizations is a failure to

appreciate the importance of some form of direct assistance to the executive. Unless her staff is small no director is able to give personal attention to all details, and the overburdened director sometimes hesitates to ask for what seems like personal relief. Instead, she struggles on alone trying to meet impossible demands in ways that react most disastrously both on herself and the work. One person can rarely give good and rounded service to all the aspects of an active public health nursing association. She either fails in proper attention to necessary details because of the demands of larger issues, or she is so buried in routine that she has no leisure for matters of development or policy. Even if an able woman, possessed of unusual physical strength and rare powers of balancing conflicting demands, does succeed in doing justice to all sides of her work, her organization is still in a precarious position in case of her illness or withdrawal. All work suffers severely from being turned over to unaccustomed hands and there is no situation so stable as to be beyond the possibility of volcanic upheaval through illness or unexpected catastrophe. No false fear of seeming to seek personal relief should prevent a director from asking for an assistant, and no false economy on the part of the board of managers should delay acquiescence in such a request.

Perhaps the relation of a director to her assistant is one of the greatest tests of leadership that exists, because a good assistant is usually also a leader herself, and it is proverbial that leader does not dovetail with leader easily. Great generosity is undoubtedly required on both sides. There are a few born assistants, women with the qualities necessary for a responsible position who yet lack the desire, or perhaps the ability, to act as first in charge. Such women, however, are rare, and unwelcome as the admission may be to the director who has learned to lean heavily on a valued lieutenant, a first-rate assistant is usually a director in the making, and should in the course of time be passed on to that more responsible position elsewhere. There are a few exceptions to this general rule in large organizations where the position of the assistant is one of great importance and responsibility, or in others where the director and her

assistant, through the possession of complementary attributes, make possible the best form of team work.

A director usually welcomes a new assistant with delight, and the first months are happily spent by both women in doing together work which had become a serious burden to the director alone. She is glad to turn over many details for which she has not had time, and the assistant in turn is glad to assume new and varied duties. The difficulties of the situation are rarely appreciated, and small account is taken of a number of tiny straws that show the presence of a gentle breeze which later may become a tempest. Gradually the assistant begins to realize that though her days are full she never goes home with her former sense of accomplishment, nor does she seem to awake glad of the opportunities of another day. Her vaguely worried inquiries as to her usefulness are met by her director with an assurance that she is becoming a perfect assistant and a source of constant comfort. So she is. The director finds her own capacities doubled. She can make twice the number of engagements, twice the number of appointments, twice the number of contacts of every sort, because what she cannot attend to herself can be delegated to her assistant who is rapidly becoming her second self. She is by no means unappreciative, but she does not stop to ask herself why her assistant seems so much less interested and enthusiastic than she used to be. The inevitable resignation comes as a bolt from the blue. The director is astounded that so satisfactory an assistant should want to leave her, but she courageously sets to work to teach assistant No. 2 "her ways."

Before she begins let her ask herself a few questions. Does any woman of ability want to be a second self to another person? Can the creative power ever be crushed without killing the joy of life and stunting all growth? Are undefined duties, really, in most cases, left-over duties, likely to be particularly satisfying? If the director is an intelligent woman it will not take her long to find an answer to these questions, and her second essay with an assistant will be more successful than the first. She will seek, in her second assistant, a co-worker whose consideration of matters of policy as well as matters of detail will prove jointly stimulating. She will assign to her certain

definite and interesting fields of work, within which a broad initiative is permitted for the exercise of the creative faculty and she will try to make sure that this assistant has her own place in the community. She will realize that she cannot herself claim all the stimulation of meetings, conventions, etc., expecting only output from her assistant, but will see that some, at least, of these plums must fall to her assistant's lot. In other words she will not try to create a shadow of herself, but will help to develop a personality, and in so doing will find that all the benefits have been mutual. When resignation comes, if come it does, it will be a very different resignation from that of her first assistant, for she will be handing on to some other organization a happy, experienced woman who is likely in her turn to make a good superior officer to those who work under her.

This general principle, rightly applied to the staff as a whole by both director and assistant, will usually be found workable all the way down the line to the youngest nurse.

The old order of military discipline in nursing is passing, giving place to what is known as democratic leadership. The executive of a public health nursing organization no longer commands a detachment of obedient and docile soldiers, but works instead with a group of intelligent women whose judgment and counsel are of inestimable value in supplementing her own. In many organizations the supervising group plays an important part in policy making, and this is as it should be. If, however, a director, in assuming a new position, is called upon to take charge of a staff unused to such responsibility, she will find it necessary to go slowly in changing the old régime. Before throwing too much responsibility upon nurses unaccustomed to exercising it she will do well to spend a year at least in preliminary training, carrying her staff slowly along the road of logical thinking on the broader principles of policy and organization. If her efforts are concentrated on a small group, as for instance, on the supervising group, she will be surprised at the change produced in even a few months of effort.

How shall *esprit de corps* be developed in my staff?—is perhaps the question most frequently asked by a new director. An answer is not easy because the intangible things of the spirit

are never readily accounted for, though a failure to gain this priceless attribute of group management is sometimes due to causes which we recognize quickly enough in slightly different circumstances. We hardly expect a lively social sense in a poorly housed, underfed, overworked member of society. Before trying to inculcate it we make every effort to improve physical conditions. Can we expect *esprit de corps,* which is in a way the group expression of social sense, in an overworked, poorly paid, badly guided group of nurses? Obviously not, and the first step should be such reorganization of working conditions as will satisfy a sense of justice. This accomplished, or on the road to accomplishment, a foundation is laid on which it will be possible to build more intangible things. *Esprit de corps* is a little difficult to define, but by it is usually meant that type of team work which has for its inspiration loyalty and unselfish devotion to a common cause. Once established in any group it is more or less self-perpetuating. In a group of nurses each new member of the staff accepts tradition as she finds it, readily contributing her own quota of group spirit to the common whole. To build up *esprit de corps* where it has never existed is quite another thing.

Staff ignorance is often at the bottom of failure to produce desirable results, ignorance of the work as a whole, ignorance of achievement, ignorance of causes of failure, ignorance of the work of other members of the staff, ignorance of future plans. The first practical step toward changing this situation and disseminating knowledge is the inauguration of routine staff meetings which will be recognized as educational opportunities. Where for reasons of economy group meetings must be infrequent as in organizations where the nurses cover a large area of country, the question is more difficult. Some form of monthly bulletin can supplement the rare meetings and should be carefully compiled. The bulletins of some of the large state health departments are of great value, but even where little money is available, some simple form of monthly news letter will be found helpful. Even at considerable expense, however, the nurses should occasionally be brought together.

The type of staff meeting held will depend somewhat on the

nature of the work, and somewhat on the size of the staff. The smaller the staff the simpler will be the conduct of the meeting, because with a small group, discussion is so much more readily secured. For a staff of over twenty-five nurses slightly more formal meetings will be necessary, but every effort should be made to retain as informal and intimate a note as possible. In city or town work weekly staff meetings are the general rule, but where the staff is large and distances long to a central place of meeting, frequency is reduced. In these circumstances arrangements can be made for interval meetings or conferences at each branch station.

No wise director will undertake to administer the affairs of her organization without leaning heavily on her group of supervisors for council and support. Supervisors' conferences must be held frequently and at stated intervals. Not only will these meetings be found an invaluable means of reaching just conclusions but through them may be established an *esprit de corps* which will be handed down through the ranks. They should be kept exceedingly informal and a very free expression of opinion encouraged from every member of the group. Both staff and supervisors' meetings should always if possible be presided over by the director herself. The nurses need her, and she needs this periodic contact with the group as a whole, if she is to know intimately the problems and personalities with which she is to deal.

Much thought is required to make staff meetings, held week after week and year after year, continuously interesting. This will never be accomplished unless the nurses themselves take part, but neither will it be accomplished without a strong positive leadership at each meeting. A folder kept through the week for items of interest to the staff will help to prevent last-minute agitation. Internal affairs should have their place; such as affairs of the staff, decisions of the board, pleasant or unpleasant criticism, interesting statistics, etc. Municipal or state interests should receive attention and a certain amount of time devoted to national or international nursing interests. New methods of medical or nursing treatment may be described, or books reviewed. All these things need not be done by the direc-

tor herself,[1] indeed it is better that the nurses should do their part in making the staff meetings interesting, but the director will find that she will have to carry a very definite responsibility herself or the meetings will show a tendency to lag. Ten minutes given to spirited community singing under good leadership is effective in refreshing a tired staff or in waking up a phlegmatic one. The occasional question box is sure to arouse discussion in the hands of a competent leader, and discussion is of all things most to be desired. Every question asked and every opinion offered must be received with respect, and the nurse made to feel that her contribution has been truly welcome. Sportsmanship in the power to carry on a spirited discussion without rancor will have to be slowly developed, and no discouragement must be felt if this is not accomplished at once. Outside speakers afford an excellent change, but the habit—an easy one to drop into, of giving over staff meetings to outside speakers—is unwise. A director needs the majority of the staff meetings throughout the year for staff purposes, and she cannot afford to part with too many. It is usually well to omit staff meetings altogether during the summer months or to hold them less frequently, in order to assure a fresh interest in the autumn.

The question sometimes arises as to whether staff meetings should be used for educational talks on subjects not directly connected with public health nursing. The answer will depend somewhat on the topic chosen, and somewhat on the educational opportunities offered by the community. In small communities where there is a dearth of educational opportunity this may be permissible, but it must be remembered that the nurses' time belongs to the organization and must therefore be used appropriately.

Disciplinary matters are a source of anxiety to every leader. Discipline is perhaps too harsh a word to apply; but by it is meant those situations requiring the correction of individual nurses. The responsibility for dealing with such situations cannot be escaped by any director. Discipline is usually reduced to the minimum with a group of nurses, for hospital training has already taught the necessity of authority, and team work

[1] Arrangements for staff meetings may be delegated to a committee of the staff.

has become familiar through ward duty. Nevertheless group management implies an adjustment of the individual to the group, and this is a process which does not always prove agreeable to the individual.

There are several types of offenders. In one group is the nurse whose work is good but whose judgment is poor, the nurse who fails to fit into the general scheme because of too great individualism, the nurse who is doing her best but whose capacity is limited, the nurse who falls below her average whenever she becomes physically exhausted, the nurse who fails in minor details such as personal neatness, orderliness, accuracy in record keeping, etc., the nurse who occasionally forgets. These nurses are all well intentioned and probably honestly want to improve. Each will naturally require different handling, but a sense of proportion must be kept. None of these failures should be dealt with as if it were a deadly sin, but merely as a situation which, for the good of the work as a whole, cannot be permitted to continue. Such nurses can be helped to work out their own salvation, and once a good group spirit is established they will recognize this fact for themselves. Tardiness is not a crime, but they will see that a tardy staff is none the less a poor staff.

In quite another class is the nurse who persistently fails because she is not sufficiently interested to reform, the nurse whose word cannot be absolutely relied upon, the nurse who is unkind to a helpless patient, the nurse who is a systematic troublemaker. These nurses are a menace to the whole organization.

In a class by herself is the nurse who loves public health nursing and who consistently does her best, but whose limitations of education or native ability bring that best below the required standard. Such a woman should be very gently dealt with, but it is useless to spend too much time upon her. Sometimes she can be fitted into a niche where she will have a certain value, but as a rule it is better to tell her frankly and kindly that she is not fitted for public health nursing work, and advise her resignation. The demands made upon public health nurses are certainly not decreasing, and there is no kindness in keeping an incompetent nurse on the staff for two or three years and then getting rid of her on the ground that she is not able to do the work.

The double duty of playing the game by the organization and playing the game by the individual members of the staff is by no means easy. Every director has suffered under the necessity of releasing a faithful nurse who was perhaps engaged at an early stage of the organization's development and who has borne the heat of the day, when hours were long and work was hard, but who for one reason or another cannot meet the advancing standards of requirement. One can only say that in the long run, absolute honesty is the truest kindness, and that such happenings are part of life's discipline. Quite as difficult is the situation where a nurse possessed of unusual powers for pioneer activity succeeds, by this very ability, in developing her work beyond the point where she is its best leader. This is a common dilemma, because the qualities demanded at one stage of development are by no means those required at another. Again we can only recommend honesty. It may be the fate of such a nurse to spend her life in abandoning one piece of work after another in order to use to the best purpose the peculiar powers that have been given her.

In talking with a nurse about her faults and failures it is usually wise to arrange for two interviews. A nurse who is suddenly called into the director's office to hear of her misdoings is at a distinct disadvantage. The director has not only the advantage of her superior position and own office chair, but she has had time to plan the interview. The nurse taken by surprise is apt either to be rendered inarticulate, or to be so put on the defensive that she will have recourse to an unpremeditated self-justification to which she will feel committed, and which will later prove a stumbling-block to true understanding. More satisfactory results will usually be attained if the director after quietly stating the case says, "You would probably like to have the same opportunity that I have had to think this over calmly. Come in tomorrow when we shall both be in a better position to express ourselves and when we shall understand each other more readily."

It goes without saying that in apportioning blame it is the offense that should be primarily considered, not the results of the offense. A quite natural error of judgment in a young nurse may result in bringing down the wrath of a whole cooperating

agency upon the head of a luckless director, causing her endless trouble and disturbance, while the wilful deviation from truth of another nurse may have no results at all beyond a misleading statement buried in a filing cabinet. The first offender, however, requires, and should receive, merely a few words of advice which will guard against a repetition of the mistake. The second offense may mean dismissal from the staff.

Dismissal from the staff of a public agency is often quite out of the hands of the director of nurses. There are two ways in which a nurse may leave the staff of a private organization. She may comply with a suggestion that she send in her resignation, in which case the reasons she gives for so doing are her own affair, or, she may be asked to resign. The former method will usually answer every purpose, but once in a great while a flagrant case of carelessness or misdemeanor demands for the sake of the work, or the other members of the staff, more formal action. This should be a last resort, but it is a responsibility that must not be shirked when occasion demands it. In making such a decision, a director will naturally want the support of her nursing committee, and if the offending nurse desires it she should have an opportunity of presenting her case to the chairman or to the committee as a whole. This she should be able to do in private if she prefers. Dispensing justice that will seriously mar the career of a young woman is a heavy responsibility. Wisdom, sympathy, kindness, insight and the power of logical deduction are all needed, and may well be prayerfully sought. Sometimes in spite of dismissal, so friendly a relationship may be saved from the wreck, that a director finds it in her power to be of assistance in helping the offender onto her feet again. A fault which makes continued work on the old staff impossible does not always preclude a new beginning on another staff, and satisfactory arrangements can often be made for a trial elsewhere provided an adequate supervision reduces danger to the minimum. Most directors are glad of the opportunity to lend a hand at such a turning point in a nurse's life, but the responsibility involved must not be underestimated. It is usually best that no one in the new organization, except the director, the chairman of the nursing committee and the supervisor who must assume immediate responsibility should know of the past his-

tory. Occasional talks will be required to stimulate courage, but the healthiest atmosphere for recovery is trustfulness guarded by a suitable oversight. The cold, hard necessity of acquiring a new record that will offset the old one should be made very plain.

If we seem to have dwelt at great length on the nurse who has failed in one way or another, it has merely been because the problem is one that always takes toll of time and thought. The great mass of public health nurses do not fail, but go quietly on their way responding to new demands and doing their duty with a high spirit of service. There are those who believe that because the staff nurse is better paid than formerly and has more reasonable hours of work, she has lost something of an earlier spirit of devotion. Twenty years ago there were but a handful of public health nurses. Today there are over eleven thousand. Among this large number there are undoubtedly some who fail to reach the high standard expected. How could it be otherwise? For those who are closest to the rank and file of public health nurses, however, the surprise lies not in those few failures, but in the fact that so large a number do reach a high ideal. If salaries are higher and hours shorter it is because a just wage and working hours which make for continuous service, have been found better policy. In pioneer fields the public health nurse is still enduring hardship, still nursing day and night, and still, alas, breaking down in the same old way.

One marked change is, however, taking place and must be taken into account in dealing with the present-day staff. A staff nurse is much younger than formerly. In the earlier days only women of mature judgment were considered suitable for district or visiting nurses, and few younger nurses cared to undertake it. Little or no supervision was furnished and the pioneer nurse, even in big cities, worked in an isolation unknown today. Now the young graduate is attracted to the public health field, means of postgraduate training are provided, and since her inexperience of life must be supplemented, careful supervision is furnished for her guidance. All this is good, but the director who has been long in the work must not forget that the young nurse is a girl of today and not a girl of a past period. The independence of thought and manner which sometimes

manifests itself in such surprising ways is in its essence essential to the present-day demands of public health nursing work.

Every staff should comprise both old and young, with a preponderance preferably of the latter. Years do not always imply age, or the lack of them youth, but as a rule the old in years are wiser and more stable than the young; while youth brings enthusiasm, buoyancy, courage and that quality which admits no obstacle. If the director is herself young, she will be fortunate if she can attract to her staff a few older women, and if she is wise she will gain much from their seasoned judgment. If she is older, she must train herself to see constantly with the eyes of youth, and not allow her added years to act as a barrier between herself and her young nurses.

Personal intimacies between a director and members of her staff are generally condemned, but since the wind of friendship has a way of blowing where it listeth, and since friendship in the highest sense of the word is too precious a thing to be lightly abjured, such wholesale condemnation seems too sweeping. Nevertheless a word of very serious warning is necessary, for the wisest administrators have gone aground on this particular rock, wrecking with them fine pieces of work. The wisdom of Solomon will be needed if such a friendship is to prove harmless to the work.

A busy director is apt to feel that most of her troubles arise from a niggardly arrangement of time which gives her only twenty-four hours a day in which to eat, sleep, play and do her work. She usually knows what ought to be done for her staff, but the doing of it in the time at her disposal is another thing. With large staffs much must, of necessity, be delegated; but beyond a certain point delegation is impossible, because a true leader leads, not alone through wise forms of organization, and the selection of good lieutenants, but through the influence of personal character which after all, is, and always will be, the most vital influence in the world.

For the director beloved of her staff, everything is simplified. Therefore the question "How can I make my staff love me?" is not an idle one. There is, however, no answer, because no group has ever been *made* to love a leader. Respect may be won by any director who resolutely and fearlessly sets herself to work

to earn it, but love comes only without conscious effort. Every relationship of life has its own peculiar temptations, and the greatest temptation of leadership lies along the seemingly innocent path of a natural desire to stand well in the eyes of the led. A recognition of this temptation is half the battle, for it is easy to make those small bids for popularity which so well stimulate a better thing, without fully realizing the motive which prompts the action. Such effort always defeats its end. A concession made, not because it seems wise or right but because favor is to be gained thereby, may indeed result in a temporary success. The individual who profits by the concession will find it momentarily agreeable, but a group as a whole never likes slack or easy-going methods. It soon tires of the loose, careless rein and demands more expert handling.

What a group of nurses really wants in its leader is a woman whose knowledge of public health nursing exceeds their own, who can be depended on to dispense unfailing justice, and whose heart is kindly and sympathetic. The leader who is honestly struggling to fulfil these requirements can forget herself, for her position in the hearts of her nurses will be impregnable.

Chapter 6

THE PUPIL NURSE AND THE NEW NURSE

From the point of view of preparedness for the work the staff of an average public health nursing organization is made up of four types of nurses: the undergraduate nurse who is sent out from her affiliating hospital for training, the young graduate who is without special training or experience, the older nurse who is lacking in special training but possessed of practical experience, and the well-qualified graduate of a public health nursing course. Were it possible to accept only nurses of the last group the problem of suitable preparation would be eliminated, but at the present juncture this is rarely the case, and the question of the provision of definite educational opportunity for staff nurses must be faced by most organizations.

Though the position of the new staff nurse is fundamentally different from that of the pupil nurse in that the latter is avowedly primarily a student, from the point of view of theoretical background, the two are often equally unprepared for the public health field. Yet for years a sharp line of demarcation has separated the pupil nurse and the staff nurse. To the pupil positive instruction has been offered in one form or another; rudimentary enough in many instances it is true, but instruction nevertheless. To the staff nurse, until very recent years, has been accorded as a rule nothing beyond, at best, an educative supervision of varying degrees of excellency.

The difficulties of the situation are not underrated. Educationally the staff nurse presents a far more difficult proposition than the pupil nurse. The latter is frankly a student. She receives no salary and her education can easily be made a first consideration. The working time of the staff nurse, on the other hand, is paid for by the public, and only in rare instances can time for educational purposes be arranged except at the expense of actual work or by means of additions to the staff,

methods in either case affecting the budget and the cost of visits. In spite of the difficulties, however, experience has shown that a certain amount of time spent on the education of new nurses is not only justified by the added efficiency attained, but in the long run proves an economy. As the educational problem presented by the two groups has much in common, it seems fitting that they should be considered together.

The Committee to Study Nursing Education of the Rockefeller Foundation, as we have seen in a previous chapter,[1] does not endorse undergraduate training in public health nursing, in so far as it represents specialized preparation for a single field, on the ground that time is often made for it at the expense of basic hospital work and also because only a few selected pupils from any training school usually profit by it. Excellent as these reasons are it cannot be denied that much will be lost to the pupil nurse, whatever her future work may be, by the complete abandonment of all undergraduate training in public health nursing, for she will be deprived of certain advantages difficult to obtain within the walls of a hospital. By seeing her patient in the natural environment of his own home, and ministering to him there, it has been found that she acquires a sympathy and understanding hard to awaken under the less normal conditions of ward service; her initiative and teaching ability are tested; and, most important of all, through her preventive work, she acquires a health point of view that the hospital, dealing as it does with the sick alone, cannot give. In addition she gains through personal experience an actual knowledge of public health nursing that will help her later to decide her future line of work, for she will have some gauge of its opportunities as well as her own fitness for it. Moreover, as has been mentioned in another chapter, the public health field offers definite advantages in rounding out and supplementing the hospital training in certain lines of work.

The Committee of the Rockefeller Foundation suggests as a substitute for present methods, that instruction in preventive medicine and social interpretation be given throughout the hospital training followed by a postgraduate course in whatever special line of study the student may elect. Though with the

[1] Part I, Chapter 5, Section 1.

proposed reduction of the period of training to two years and four months, postgraduate work would be possible within the three-year limit now given to undergraduate preparation, many nurse educators believe that more assured success will be secured by holding the students for three years in the hospital as at present, and offering elective courses in specialized work during the third year, thus assuring to every student before graduation the opportunities for study recommended by the Rockefeller report.

In any event, country-wide changes of this sort take place slowly, and as many hospitals will undoubtedly for the present continue to affiliate with public health nursing organizations for undergraduate training, a few words as to the safeguarding of such arrangements may not be amiss.

Some of the postgraduate courses are open to undergraduate students, a diploma for the course being given with the diploma of the training school. Others offer half the course before graduation, with opportunities for completion later. Such organized training is, however, the exception. For the most part it is given in a more or less unstandardized way by public health nursing organizations that receive pupil nurses from local hospitals for short periods of time, the usual allowance being two months.

In the past there was a temptation, too often yielded to, on the part of struggling public health nursing organizations, to gain for themselves an extra nurse without expense by asking for a pupil from one of the local hospitals. No injustice was intended but only the point of view of the organization was considered, and an increasing number of calls, without a correspondingly increasing budget, drove the managers to this means of solving their problem of expansion. Bare experience was mistaken for training, and no one saw the wrong principle involved, least of all the pupil nurse herself, glad of a change of work and often too ignorant of educational standards to appreciate the situation. This early history has naturally had its effect on present conditions, and in any consideration of the problem of undergraduate training, account must be taken of the fact that long before the necessity for special education for public health nursing was formally recognized, and long before the first postgraduate course was offered, hospitals were sending out their

pupils to visiting nurse associations for experience. No educational demands were made of the associations beyond that of a general field supervision, and, as we have said, even this was rarely insisted upon. Where several hospitals were affiliated for such service, each training school maintained its own schedule for hospital classes and lectures to which the pupil must be returned, and each also rotated its nurses through the visiting nurse association at its own convenience, thus disrupting all efforts at continuity of training.

More than an echo of these methods lingers today. Many organizations are still struggling with a like point of view and like arrangements, though a growing appreciation of the importance of a suitable preparation for public health work is gradually changing conditions. It is easy to say that such affiliations, lacking as they do many of the essentials of educational opportunity, are non-constructive and should be ended. Is it not perhaps better to retain them and start an educational process, simple though it may be in the beginning, that will eventually develop into something truly satisfactory? The large organizations with their university affiliations make an enormous contribution to the cause of public health nursing education, but the small organization is also capable of furnishing excellent teaching material, if rightly utilized, and may well do its part in furthering the common end.

In considering, therefore, the question of undergraduate training it must be remembered that we have at one end of the line the large, well-equipped organization carrying a postgraduate course in affiliation with an educational institution, and possessed therefore of every facility for teaching, and at the other end the small organization with no organized teaching facilities whatever. Between these two is to be found every degree of educational efficiency and inefficiency.

There are several points of view regarding the whole question. Some students of the subject feel that no organization should receive pupil nurses unless its educational department is so organized that the time spent will form a definite unit of work for which credit will be given toward a full course. Others feel that while this is undoubtedly a desirable end toward which to work, many organizations offering less, still provide something

of real educational value that the pupil nurse can ill afford to do without, and that if certain essentials can be assured such affiliations had best continue. On the assumption that in any event this is likely to be the case, the following suggestions are offered.

Different as are the situations represented throughout the country, a few general principles may be applied to all. In arranging for affiliation with a public health nursing organization a training school should, in justice to its pupils, assure itself of two things: first, that the organization with which it affiliates is employing modern and approved methods of work; and second, that systematized and educative supervision is given each pupil during the entire period of her connection with it. This implies a nursing staff qualified to teach. An organization employing but one nurse can rarely do justice to a group of pupils or indeed to a single pupil. A staff of two nurses may, however, provide excellent training. The pupil's full working time will naturally be required by the affiliating agency and if more than one hospital is affiliated with an organization, arrangement must be made for all pupils to enter the field at the same time in order that both the theoretical and practical work may be systematically planned and carried out.

There is one difficulty that often mitigates against the effectiveness of undergraduate training, namely, the varied educational preparation of the pupils. An instructor is not infrequently confronted with the difficulty of teaching an ungraded class in which she may have college graduates and nurses who have not even entered a high school. She may also be obliged to arrange her work to meet the necessity of a return of the pupils to their several hospitals for a number of classes and lectures. If public health nursing organizations expect to give satisfactory training to undergraduate students these difficulties must be recognized and an attempt made to overcome them. A few organizations, in arranging for affiliation, make provision for a minimum educational requirement which will ensure a high school diploma or its equivalent, but this is difficult where the local hospital entrance requirement is lower than this. It seems probable, however, that time will remedy this difficulty as the hospital training schools raise their educational standards, and

as the field of public health nursing becomes more generally recognized as one in which good educational equipment is essential. This end will undoubtedly be hastened if public health nursing organizations taking pupils will raise their own educational requirements as rapidly as local training school conditions will permit.

The second difficulty, that of the return of the pupil to her hospital for classes, has already been adjusted in a number of places, though from the training school point of view such an adjustment is by no means easy. It means that all hospital classes and lectures must be brought into the first two years of training if affiliations are to be offered in the third year. Where this seems impossible an agreement between the various hospitals to reserve a common day or days for the return of their pupils for classes will simplify the situation for the affiliating agency. Evening classes solve the practical difficulty, but are to be deprecated on other grounds. Nor is the practical difficulty the only one. The hospital classes naturally bear no relation whatever to public health nursing, the subject on which all the pupils' other thoughts are concentrated. This causes such a diversion of interest and effort as to prevent satisfactory results from either line of instruction.

Undergraduate theoretical work must be arranged with relation to the curriculum of the hospital from which the pupil is taken. If this is weak in such studies as underlie the principles of public health nursing, only the barest fundamentals can be attempted. If the pupil has already learned something of preventive medicine and the social aspects of disease, slightly more advanced teaching is possible. The fact, however, must be recognized that the amount of time usually allowed for affiliation is too short for anything like completeness, and that it is far better to confine instruction to what can readily be grasped than to try to give a smattering of many things that can only result in confusion.[2] That undergraduate training as now given amounts, with a few exceptions, to little more than an introduction to the field, does not necessarily belittle its importance. Rather it

[2] Six hours a week is considered the maximum that should be given to theoretical work exclusive of individual field or office instruction, four hours the minimum.

should mean that the most must be made of so short an opportunity.

Pupils should not receive their public health training too early in their hospital course. The third year is usually considered the most advantageous, because it is important that they should be thoroughly grounded in proper nursing methods before they are required to make such adjustments of technique as are frequently necessary in the districts.[3] When the affiliations are local, the pupils continue to live at the hospital while the organization is responsible for carfare and all expenses incident to the work. Affiliations are never, perhaps, perfectly easy, but there is no reason why such arrangements should not work smoothly if both hospital and organization have a common educational ideal, and if both recognize the respective difficulties of administration and endeavor to meet them in a spirit of helpfulness. No organization will be able to give what it does not possess, however great the desire; but if the methods employed are the best, and if careful technique and a broad-minded outlook on the work as a whole are part of the general policy, there is more unconscious absorption on the pupil's part than is always realized. Certainly every public health nursing organization is the richer for its pupil nurses, for the spirit and inspiration brought in by the influx of fresh, eager young women, full of a probing interest and desire to learn, are of incalculable value, while the necessity for teaching acts as a daily incentive to good work.

Thus far we have been speaking of the pupil nurse alone. Let us now turn to the staff nurse. The fact that every staff requires the stimulation of a constant educational intake has long been recognized, and staff conferences are everywhere held in order to meet this need. The trouble is that they are usually arranged for the purpose of keeping the older nurses abreast of the times and no attempt is made to provide a background for the new nurses. It is not unusual, therefore, to find a young nurse struggling with the pros and cons of an exception to some general rule of which she has never even heard. As staff confer-

[3] The training school curricula may later be arranged to provide for a type of public health training that will extend throughout the entire undergraduate period. We allude here to the plan commonly used at present.

ences are not intended for the instruction of beginners it is obviously desirable that new comers should be brought as quickly as possible to a point where they may best profit by them.

In organizations where there are pupil nurses the identical machinery used for their education will serve equally well for that of the staff nurses.

It is unnecessary to speak of the training given pupils and new nurses in organizations offering postgraduate courses. These are fully equipped for teaching, and have but to adapt their educational methods to the needs of their pupil and new-nurse group. The organizations less fortunately situated must make a definite plan of campaign. If the number of pupils and the turnover of the staff is large, the appointment of a well-prepared educational supervisor is more than justified. She will plan the theoretical outlines, and arrange for all classes, lectures and demonstrations that she does not give herself, and she will work in conjunction with the district supervisors in providing educative supervision in the field. In large organizations field supervision will probably be furnished almost entirely by the district supervisors, the educational supervisor acting as consultant. She will need, however, to keep in constant touch with the work of her students, and for this the "experience sheet" which gives detailed information regarding the actual disposition of the students' time will be found useful. It is not until such a record has been carefully studied and the work done analyzed in the light of its educational value, that it is realized how easy it is to allow a student to spend her time on an unbalanced program from which may be omitted some of the most important types of work. All district supervisors are hard pressed by the daily demands of their districts, and in dealing with their pupils and new nurses need stimulation and assistance from some one solely interested in the educational point of view.

In small organizations the educational supervisor will be able to give a certain amount of field instruction herself, though it is unwise to remove all responsibility for this from the other supervisors. Where pupils and new nurses are few their training may require but part of a supervisor's time, the rest of which

may be utilized for administrative work. When no educational supervisor is available the director must herself generate the educational spirit, and carry on as much of the educational work as cannot be advantageously delegated to others.

Because it is important that the nurses should be in the field in the morning carrying continuous responsibility for their cases,—classes, lectures and demonstrations are best given in the afternoon; and these, no matter how simple and elementary, should be so arranged that the nurse will receive from them a clear idea of public health nursing itself as well as very exact instruction regarding the duties expected of her. The practical work and the theoretical work should be closely related, and in both the teaching must be uniform and consecutive. Time spent in a well-arranged and standardized introduction to the field will be found well worth while. Demonstrations of such routine procedure as can be taught outside of the home are excellent if well arranged. The first few days should be spent with a supervisor, after which a nurse may begin to visit alone, though throughout the entire period of training she should be accompanied at frequent intervals by her supervisor. It must be remembered, however, that while supervision is necessary, resourcefulness cannot be taught through observation alone, and the student must early be given responsibility and encouraged to think for herself. It is not difficult to teach necessary details by means of office demonstrations, but the essential point in such instruction is not to teach the use of newspapers instead of dressing towels, but to teach the use of the mind in replacing accustomed equipment. The same is equally true in training the powers of observation. It is easy to teach that certain specified conditions must be observed, but, as we all know, unless observation becomes a veritable sixth sense the fullest success in public health nursing cannot be attained. Therefore, though the patients must be protected from inexperienced handling, in apportioning work the educative value of complete responsibility must continually be remembered. A manual containing all necessary information with instructions regarding methods, technique, rules to be observed, etc., is an indispensable adjunct to teaching and most important in assuring a proper standard of work and a comprehension of its purpose.

In considering any such educational adjustments as those suggested in this chapter one point must be kept clearly in mind, namely, that we are at present passing through a stage in the development of public health nursing education when temporary expedients are necessary. The university training schools, the fine hospitals, the postgraduate courses will in time train our leaders, but pending the day when adequate public health training is possible for every nurse before she enters the field, we must meet the present need for some sort of training for the rank and file who are doing the actual public health nursing of the country. Though no executive agency like a visiting nurse association, or other nursing body whether public or private, is well fitted to develop alone a purely educational project, public health nursing organizations will always probably be participators in any program for public health nursing education, in as much as they will continue to provide the practice field. Moreover, the education of a staff is never finished and a staff nurse should be a student to the end of the chapter. Many organizations will feel the call to ally themselves with the larger educational programs, and all, unless they wish to stand still, must accept the responsibility laid upon them by circumstances, and take the education of their own nurses as a serious duty to be discharged to the best of their several abilities.

Chapter 7

THE NURSE WORKING ALONE

In the preceding chapters of this section we have spoken principally of the nurse who in one position or another is doing her work as a member of a staff, and who has therefore the advantage of group association. All that has been said must to a certain extent apply to the nurse who works alone, but in addition to those relationships and responsibilities already spoken of such a nurse encounters a number of problems so peculiarly her own that they seem to warrant special consideration. In reading the present chapter, however, the nurse working singly must remember that it cannot be taken alone by itself but should be read in connection with those chapters that bear upon the subject of her work in its relation to her responsibility to her patients, her board, her community and those wider aspects of public health nursing that lie a little further afield. For the Red Cross nurse excellent literature already exists in the form of bulletins describing the organization of public health nursing in Red Cross chapters. For those special problems incident to state, county and municipal nursing, and for consideration of the special branches of public health nursing, the nurse working alone is referred to Part III and Part V respectively.[1] Here we shall consider chiefly the nurse who undertakes alone the work of a private organization, either in a small town or in a rural community.

Not infrequently this work is started by a nurse who has had experience as a member of a city staff, or has taken a postgraduate course in public health nursing, but to whom the inauguration of work in a new field is an untrodden path. In taking up her duties such a nurse must be prepared to consider the health problems of her community as a whole, and while never forgetting the individual welfare of her patients she must

[1] The nurse in the country is especially referred to Part III, Chapter 2.

give time and thought to many things beside individual nursing and instruction. Her work is likely to prove full of interest because of the variety of duties that she will be called upon to perform and the variety of subjects about which she will be called upon to think.

In the first place she must expect to give serious thought to the administrative side of her work. If the organization by which she is engaged is just being started, a certain amount of very definite leadership will at once be required in relation to her board of managers, and there is one point upon which every nurse should insist, namely, that regular meetings of boards and committees should be held. Sometimes the members of an organization that has been formed with considerable enthusiasm will feel that they have done their part when, with great effort, the necessary funds have been raised and a nurse found to do the work. On her arrival they are quite ready to leave everything to her, saying politely, that she is to call on them in case of need, but not, as a matter of fact, expecting to attend meetings or to carry responsibility except in emergency. This, if the nurse permits it, is fatal to a strong and safe organization. If no emergency arises, and the nurse is resourceful, things may slip along with perhaps occasional irregular meetings; but when the second year arrives and the budget must be met, it will be found that no one is particularly interested in securing it. Or when emergency arises and the nurse calls her board together, she will find that, having followed her efforts so little, they are too far behind really to understand or answer her call for help intelligently.

Regularity of meetings, therefore, should be a nurse's first care, for without such regularity she is so helpless as to be quite justified in declining to continue a connection with an organization so unwilling to do its part for the public health of its community. Having secured regular meetings, her second care should be the use she makes of them, for they must be looked upon as opportunities, not as interruptions to other work, and made the most of as such.

The members of a board are called together largely to assist her in what she is trying to accomplish, but they can only do this successfully if they are kept intelligently informed of her

efforts and plans. It is unnecessary to speak further of the relation to her board of the nurse working alone, for such relationship differs little from that of the director of any organization to her governing body and of this we have spoken at length in other chapters. The city-bred nurse, however, in dealing with a country board must realize that when there is a difference in the point of view it is her board that probably represents the attitude of mind of the community, and the same is true when a nurse goes to an unfamiliar part of the country which has different local traditions from those to which she has been accustomed. She need not give up her own point of view, but may so present it, and so adapt it, as to make a good working basis on which she and her board may proceed. Many an otherwise good nurse has failed because of her inability to understand conditions that were new to her. A Northern nurse working in the South will accomplish nothing by ignoring the question of color. A Western nurse must try to understand the importance of tradition in an Eastern village. North and South, East and West have much to bring to each other, but the gift will only be acceptable if wisely bestowed.

The importance of suitable and accurate records must be recognized from the start. Slack methods of record-keeping are of the past, and the necessary blanks that will save the nurses' time in recording data will be found an economy, not an extravagance for even the smallest organization. Records, no matter how simple, should be kept always up to date, in order that necessary information may constantly be available and also that in case of illness or sudden absence the situation may be clear at a glance to a substituting nurse.

The first difficulty of the nurse who goes from a well-organized city organization to start work elsewhere will probably be her lack of patients. Time is required for any new idea to take root, but while she must have patience, it is not enough to sit peacefully down and wait for cases to come to her. The unoccupied time of the first few weeks can be spent to the best possible advantage in laying a good foundation for future work. One of the simplest modes of entry to the homes is through the schools, and for that special arrangements must be made with the proper authorities. The board may also send out to every

physician a short written or printed notice explaining the work, and stating under what conditions the nurse's services may be obtained, and how to communicate with her. This, however, will not usually be enough. A personal call on each doctor will do more to establish comfortable relations than any amount of printed information.

And here a word of warning may be sounded for the nurse fresh from her postgraduate course, or with her years of city experience behind her, who, because it wears an unfamiliar garb, may not recognize the very thing she is looking for. She may perhaps be possessed of untold stores of knowledge, and be fairly alight with the fire of instructive zeal, but these claims to ability are not always the best introduction to the medical practitioner, who has never seen a public health nurse before. Her peculiar form of social training may seem to him of little worth, while the instructive zeal is either amusing, or terrifying, according as he belittles or magnifies its importance. What he wants, if he is to have a nurse at all, is "a good honest woman, who will keep his patients clean and do just as he says."

Such a doctor is quite justified in his conservative attitude. For years he has probably worked faithfully and well among his people, finding often efficient assistance in some good experienced nurse or intelligent member of the patient's family. It is most natural that this new type of nurse should be obliged to win her spurs before he gives her his confidence.

Instead of feeling a hopeless despair because her training and ability to instruct are unappreciated, she must set herself to gain his approval, not by overmuch talking or an effort to change his point of view, but by showing him that she is the honest woman he is looking for, capable of giving thorough baths and obeying directions. When these facts have been established in his mind he may be ready to show her that he, too, is not so ignorant of social subjects as he seemed to her at first, though he may not use the latest terminology; and that his unremitting though perhaps unorganized efforts to teach the people how to keep well, have produced results that have had an effect on the entire community. Of course all doctors are not of this type, and with some the nurse will never work sympathetically, but as we have reiterated so many times, the rules of professional

etiquette must be none the less observed. It is far better in the beginning to err on the side of an overscrupulous observance than to gain a reputation for an easy morality on this subject. A nurse undertaking new work is sometimes heard to say, "Here I have to be so careful with the physicians, but in ———— all the very best doctors allowed me to use my own judgment for many of the minor things." Such a nurse forgets that these men, after years perhaps of experience with her, had proved her powers, and also that behind her she had the strength of an organization that had grown to be a civic force. This strength the nurse striking out for herself often misses, though she does not know what is wrong. Prestige is an intangible thing, but for nurses working in established and valued public health nursing organizations it smooths more rough roads than they ever realize until, without it, they try to make themselves felt on their own merits alone.

In working with the doctors it is wise to take whatever is offered in the way of cooperation. With some it will be the generous-minded welcome accorded a co-worker, with others merely a grudging tolerance hard to accept. The nurse, however, who is able to feel that her services are being used by all the doctors of her community, even though the terms of such cooperation may not be altogether to her liking, can well congratulate herself on her success.

After the physicians have been called upon, it is well for the nurse to make herself acquainted with the other workers of the community and here she must again be careful. She must forget her desire to teach, and become a humble learner at these interviews, for the advice and information she may receive will be most helpful. Even when her opinion is sought, let her be a little wary in expressing it. She is sure to be quoted, and further knowledge of conditions will often modify an early opinion.

Above all she must be careful not to be drawn into any of the local feuds or disputes that sometimes flourish so amazingly in small places, which, if entered into, would curtail her usefulness to an opposing faction. This she may do quite unconsciously and in ignorance, when she is a stranger, unless she is on her guard to avoid it. She will, of course, make her own friends, and should be as free to do so as any other private

individual, but nothing must be allowed to interfere with her usefulness to all, and she will naturally remember that the dignity of the organization she represents is increased or diminished through her.

In the first less busy weeks she may make excellent use of her time in a study of town or county statistics. A comparison of these with those of other localities will tell her whether the infant death rate is relatively high, and by them she may learn in what houses deaths from tuberculosis have occurred, if typhoid is epidemic, whether contagious diseases have been devastating in their effects, and other like pieces of valuable information. The health officer may be a great help or a real hindrance to her work. Which of these he becomes will somewhat depend upon her first approach to him. In all these efforts to get started a nurse must be careful not to adopt a critical attitude, or, still more irritating, a patronizing one, and above all, she must move slowly. What can be done peacefully in her second year might produce a tempest if attempted in her first.

A wise nurse should take the time to sit quietly down, and after due thought write in her note-book all the things she would like to change or inaugurate, dividing these into three groups: those that she can bring before her board at once asking that measures may immediately be taken about them; those that she may wisely mention, with the advice that for the present no steps be taken; and those that for a time she had best keep to herself. She will, probably, do well in the very beginning to make the first list a short one, the second longer, and the third longest of all. By constant reference to these lists she will avoid the danger, on the one hand, of alarming her board and the community by her radicalism, or, on the other, of allowing herself to drift with the tide, taking the line of least resistance and failing to make use of the opportunities within her grasp.

A good nurse quickly learns to distinguish between situations that are typical and those that are isolated. The former must be dealt with with great care, for they are foundation stones on which future progress is built, the latter are comparatively unimportant, and a point may often be stretched to advantage in dealing with them.

In every community the question of payment for services will

early claim attention. Most of the large city organizations in introducing the payment system labored under the disadvantage of being obliged to do so by means of an unpopular revolution, as almost all organizations that were started in the earlier years of the movement gave free care in all cases. This was true in England as well as in America, for Miss Hughes of the Queen's Institute writes, "In tracing the development of district nursing it is evident that the medieval idea was revived that the nursing of the poor must be an act of Charity, and all the original associations were founded on this basis."[2]

The results of such a policy, and its subsequent change, made a hard and difficult row for the earlier nurses to hoe. It can never, perhaps, be made an easy proposition while we have a sliding scale, but it will be much simplified if the nurse starts right; and any community will be as ready to grasp the idea that a nurse is being provided at cost price, or at a cost within the means of those whose incomes are small, as that a free nurse has made her appearance. It is better that the non-payment cases should from the beginning be looked upon as necessary exceptions to a general rule, rather than that the paying patients should feel that they are making use of a charity nurse. Free care should be given only when the nurse considers it a necessity; but when given the gift must be so cordially bestowed that it leaves no taste of bitterness in the mouth of the recipient.

The question of what patients should be cared for by a public health nurse is also sometimes a difficult one in a small community where private nurses are not easily obtainable, and there has been, as we know, a curious evolution of thought on the subject. At first the district nurse was considered the peculiar property of the very poor, and no account was taken of those of moderate means even though they could not afford trained nursing in any other way. Gradually the needs of this class were met on a paying, or partially paying, basis, and so successful was the work of the visiting nurse that her systematized skill was also made use of by those who, though they could afford it, did not require the continuous care of a private nurse. On this threshold, however, there was a long pause, lest if the time of the public health nurse were to be given to those who

[2] "District Nursing on Provident Lines," Amy Hughes.

could afford other care, the poor, the people for whom the nurse was primarily intended, should suffer.

This fear was not a foolish one, as every director of a public health nursing organization knows. It would have been easy to drift into a disastrous state of things wherein those needing most, but demanding nothing, would have received least. In a small community with but one nurse, where adjustment of time was difficult, this danger was very real.

If the services of a nurse working alone are to be placed at the disposal of the whole community, irrespective of income, two points must be borne in mind: first, that the patients most needing care must receive it first; and second, that any work done among those in comfortable circumstances, and therefore able to pay full price, must be completely self-supporting. This latter necessity should be no mere matter of guesswork, but such records kept as will make the situation perfectly clear on this point. If this is done there will be no temptation to allow the poor to suffer because of an overbusy nurse, for nurses can be added to meet the demand.

In communities where there is no hospital and where private nurses are not available, the question of night work always presents a difficulty for the public health nurse. No nurse can respond to constant night calls and expect to do justice to her regular day's work, for unless time is taken to make up lost sleep a physical breakdown is for most women only a question of time. Though certain exceptions to any general rule must be made to meet urgent necessity, it is on the whole not wise to allow a too great interference with the ordinary routine of the organization's activities which are founded on the regular day work of the nurse. It is a great temptation for a thoroughly interested nurse to spend the night in the house of a critically ill patient, hoping to snatch enough sleep to enable her to manage her next day's work. In the long run such a course will produce poor work. Far more will be accomplished by the discovery of a reliable woman who, either with or without remuneration, will take an occasional night of duty. A small fund may be established for payment for such work among the very poor, but the nurse used to city methods must be careful not to break down the neighborly habit of offering friendly

assistance in times of trouble that fortunately still exists in most country places.

Occasionally a board of managers, unfamiliar with the usual methods of conducting public health work, may feel that because private nurses combine considerable night work with their day work, a public health nurse should be able to do so too. Such a board may be reminded that because of this a private nurse is obliged to charge more for her services than a public health nurse, in order that between cases she may be able to take time for complete rest and relaxation. The board may also be reminded that the demand on the private nurse is a very uneven one, entailing great stress of work at one time, followed by periods of far less activity at others. The public health nurse, on the contrary, must go freshly forth equipped to do creative work each working morning of the year, and for this she must have a rested body and rested nerves.

There are, of course, rural districts where the distances are great and where even the doctor is often unavailable. These make a law unto themselves, for the work is necessarily quite different from that in villages or small towns, and must be done under different conditions. In such places a nurse to be useful may even be obliged to spend a day or two with a critically ill patient, as it would be wholly impracticable for her to leave and return to him again. Her work, like that of the private nurse, may be uneven, a rush at one time and comparative leisure at another. It would be as absurd to insist on the usual methods for these districts as to expect city conveniences. We can only urge such a nurse to look over the whole field of her activity sufficiently often to keep a broad outlook, and to remember that she has no right to allow herself to break down.

Sunday work is everywhere difficult to plan for, but a nurse working alone must arrange to reduce her work as far as possible that day, seeing only the cases that would seriously suffer if she omitted her call.

If a nurse working alone is to fulfill her triple duty, and if in addition to nursing the sick she is to play her part in preventing disease and promoting health, she must spend a certain portion of her time in purely instructive work, not alone in the homes of her already sick patients, but throughout her com-

munity. This instructive work is apt to fare ill in the stress of winter sickness unless its importance is recognized and a great effort made to prevent undue encroachment. In arranging her work a nurse must not allow herself to drift, responding merely to the nearest call, but must make for herself a definite plan of campaign. Sickness of a certain type must of course take precedence, but it is often right that a family should assume additional responsibility for the nursing care of one of its members, thus releasing a nurse for instructive work in another family where a baby's health is at stake, or where an active case of tuberculosis threatens the lives of all. The kind of far-seeing wisdom required to make such adjustments is not to be acquired in a day but many nurses who are working alone have become past-mistresses in the art of a wise apportionment of their time.

It sometimes happens that a board of managers does not understand the value of purely instructive work, and its whole interest centers around the sick-a-bed patient. In this case a nurse, through her own efforts and by means of suggested reading, must do her best to bring to them the modern trend of thought on this point, for no board should be allowed lightly to confine the activity of its organization to the care of the sick alone.

Perhaps the most difficult position in which a nurse working alone finds herself is when the preliminary steps having been taken, her efforts at publicity and cooperation take effect, and after a period of ever-increasing activity she wakes up to the fact that she has more work on her hands than she can possibly accomplish satisfactorily within the prescribed hours. Knowing the difficulty of raising funds, her heart sinks at the thought of asking for help. Confronted with this difficulty, many nurses bravely try to struggle on, keeping long hours, slighting the less acute cases, doing little instructive work, taking no time for thought, and losing the enthusiasm that is such a vital asset to good work, and in the end reaching that state of mind in which the forest is so completely hidden by the trees as to be nonexistent even in imagination.

In spite of the pluck which we must admire, such efforts merely delay a change of policy, and the nurse is making a mistake of judgment in her apportionment of responsibility, arro-

gating to herself an undue share. The care of the sick and the teaching of health in any community are the responsibility of the community itself. The community is represented in the matter by the organization which in turn vests its administrative responsibility in its board of managers. As the board of managers is itself manifestly unable to nurse the sick or teach health, a nurse is engaged to do this according to certain methods and under certain conditions which years of experience all over the country have proved productive of good results.

The nurse whose work develops beyond her power of accomplishment under these general rules should not, therefore, feel that on her shoulders rests the responsibility of finding a way out of the difficulty. On her shoulders does rest the responsibility of drawing so clear a picture of the need of the work, and how and why she is failing to meet that need, that her board will be able to act with full knowledge of the situation. Beyond this her responsibility does not go. If she has carried her board with her, step by step, in the growth of the work, it is probable that it will feel that the increased demand must be met by yet more vigorous efforts on its part to awaken the community to its responsibility concerning public health, and the necessity of supplying the funds necessary for its development.

If this is not done there should be a definite understanding, and the nurse should assist her board in the construction of a method of limitation that can be consistently carried out, keeping always in view the hope that it may be temporary. It is well, also, to make generally known the fact that a curtailment of work has been found financially necessary, for who will make the effort to buy a larger pair of shoes unless he feels the pinch of the pair he is wearing?

Sometimes a definite change of policy is required to alter the situation. The purchase of a Ford car, perhaps, which will widen the range of work, thus bringing in new interest and support, or some form of amalgamation with another organization that will have the same effect. The possible turnover of the work to a public authority such as the county or township must be kept constantly in mind. The problem of financing rural and small town nursing in such a way as to insure full

development is a difficult one, and public control in many instances offers the best solution.

One important principle often before dwelt upon in these pages must not be forgotten by the nurse working alone, namely, that no work, no matter how well it may be done individually, is really safe or strong unless it is in fact as well as in name a community effort. For this reason the first years of a new enterprise should be spent in laying a foundation on which the solid structure of the future may rest with safety and security, rather than in trying to erect an edifice, however temporarily satisfactory, that will not outlive the first ephemeral enthusiasm for something new. The perhaps popular nurse who leaves her showy but badly constructed piece of work to go to pieces on her departure deserves little of the credit that she sometimes gets; but the nurse who, after many discouragements and often little recognition, leaves an awakened community and a list of patients who feel that above all things their town must have a public health nurse, has accomplished something well worth while.

We all know that times have changed; that railroads, telegraphs, telephones, automobiles, cheap postal facilities, newspapers, etc., have brought the people of the world nearer together. The statement is a truism, and yet, not infrequently, a public health nurse is found making her daily rounds as if no such state of things existed so far as her work goes. All by herself she tries to solve each new problem as it comes up, oblivious of the fact that that very problem has probably been solved in a sufficient number of other places to make a safe precedent to be followed, or that a national organization exists for the purpose of helping nurses situated as she is.

It is no longer enough to do one's own work well. A public health nurse is not an isolated unit trying to meet unique conditions in some particular locality. She is, as we have tried so often to express, part of a large and important movement that is making itself felt all over the world.

If in the state in which she works there is a bureau of public health nursing in the state department of health, she will naturally get into touch with the chief nurse at the earliest possible moment. Help and support can be counted on from this source,

and through it a nurse's own local work may be so correlated with other state efforts as to greatly increase its value.

Attendance at national conventions should, if possible, be felt a necessary part of the running expenses of an organization, if not every year, then as often as can be arranged for. If the nurse who has enjoyed the privilege of attending a convention comes back to her board with old ideas clarified by comparison with the ideas of others, with new methods and suggestions, and full of an enthusiasm so contagious that it is felt by every member, the money spent will have been well invested.

No nurse should ignore the value of magazines dealing with public health matters, or the strength that comes through membership in nursing organizations. State branches of the National Organization for Public Health Nursing or local public health nurses' clubs help tremendously and can readily be formed.

If the nurse is in so remote a place as to be denied all intercourse with other nurses, let her not be afraid to lift up her voice by correspondence and ask for the help she needs. The National Organization for Public Health Nursing stands always ready to answer questions, and it is safe to say that it would be hard to find a public health nurse, be she the director of a large city association or an inconspicuous nurse working alone, who would not account it a privilege to be allowed to pass on, for the help of others, any experience she may have gained for herself.

Those who have the stimulus of what Phillips Brooks has called "corporate courage," meaning the courage that is sustained by that of others, usually take it as a matter of course. It is not until a nurse leaves a band of other nurses and undertakes single-handed to deal with her manifold problems that she realizes how much her own courage has been kept up by the courage of those about her.

A story has been told by an executive secretary of a national nursing organization of a letter she received asking what the necessary expense would be for her to go to a tiny western town. As the secretary was at a distance, the expense was considerable and time hard to spare. Arrangements, however, were finally made. The secretary was in the habit, on such trips, of being asked to speak at meetings, large or small, but in this instance

her hostess evidently had no such intention, for she proposed to take part of the long journey herself, meeting the secretary at a point midway. Full of curiosity, the secretary set forth, and the interview, a long one, took place in the station at the meeting place. In telling the story, the secretary said, "I found an eager, sensitive young nurse, filled with the enthusiasm of her calling, trying to meet alone a most difficult situation, and almost at the end of her courage. She so aroused and interested me by her story that I must have been able to give back to her some of the inspiration I felt, for at the end of our interview she assured me that seeing another nurse who could understand her point of view and sympathize with her ideals had helped her so much as to make far more than worth while the heavy expense of the journey."[3]

The pathos of the little story may find an echo in the heart of many a lonely nurse, for loneliness of purpose or ideals may be felt even in the midst of the warmest affection from patients and the sincere appreciation of a board of managers. Such lonely nurses must take comfort in the feeling of sisterhood and the bond of a common purpose that binds all public health nurses together wherever their work may lie, and also in the thought of the high esteem in which their contribution to this common cause is held by those who realize how greatly their own problems are simplified by the companionship of other members of their own profession.

In taking up work that must be done alone every nurse should weigh well the various advantages and disadvantages. For a woman who has always lived in a city there is much to become accustomed to in country or small town life; but the rewards are great, and for those who enjoy the exercise of free personal initiative and the idea of a fair field for experimentation and constructive effort there is perhaps in the whole range of public health nursing nothing so satisfactory as the small private organization that employs but a single nurse.

[3] These words of the late Miss Isabelle McIsaac are quoted from memory.

PART V

SPECIAL BRANCHES OF PUBLIC HEALTH NURSING

Chapter 1

TUBERCULOSIS

Tuberculosis has for centuries been recognized as a dreaded foe to the human race. Hippocrates (460 to 377 B.C.) described it as a disease which is "the most difficult to treat and which proves fatal to the greatest number." As early as the fifth century B.C. a Greek physician recognized it as transmissible through contagion, and this view was maintained at intervals throughout the middle ages by European writers. It might surprise some modern advocates of registration and compulsory segregation to know that "in Naples a royal decree dated September 20, 1782, ordered the isolation of consumptives and the disinfection of their apartments, personal effects, furniture, books, etc., by means of vinegar, brandy, or lemon juice, sea water or fumigation. Any violation of this law was punished, if the individual was an ordinary mortal, with three years in the galleys, and if he happened to be a nobleman he was sent for the same time to the fortress and was obliged to pay 300 ducats for the first offense, and repetition of the neglect would banish him from the country for ten years."[1]

Notification laws also existed in the eighteenth century in Spain and Portugal, for the purpose of insuring the disinfection of the patient's personal effects after his death.

During the first half of the nineteenth century, however, little attention was paid to the theory of infection. It was not, indeed, until 1865 that a French doctor actually demonstrated the transmissible nature of the disease, a demonstration which antedated by seventeen years Dr. Koch's discovery of the bacillus.

In America the tuberculosis campaign, as a special movement, may be said to date from 1885 when the Adirondack Cottage Sanatorium was started by Dr. Trudeau at Saranac. Soon afterward anti-tuberculosis societies sprang into existence, Pennsyl-

[1] Dr. Knopf, "Tuberculosis a Disease of the Masses," prize essay.

vania having the honor of establishing the first in 1892. Others followed rapidly, and since its inauguration in 1905 the National Tuberculosis Association has taken its place as one of the strongest and most important of the national health bodies.

In spite, however, of the recent rapidity of development, it is but a short time since consumption was accepted by the general community as an inevitable scourge which it was of little use to try to overcome. The disease once recognized, a patient was considered doomed, and if he were fortunate enough to belong to an affectionate family, it was their privilege only to make his remaining days as comfortable as possible. This was accomplished by keeping him warm and out of all draughts, and incidentally out of all fresh air as well. If poor, his days were spent by the kitchen stove, and because of his wretched nights he was rarely left alone. In many instances, space being scarce, the night care was given by a member of the family who for convenience shared the bed of the sufferer. When a year or two after the death of the patient this devoted nurse succumbed to the disease the scene was re-enacted in all its details, while sympathizing friends regretted that the Blanks "had consumption in the family."

The isolation of the tubercular bacillus in 1882, and a consequent study of its habits, threw new light on the subject, while the assertion that tuberculosis was not hereditary but was transmissible, and, if recognized in time, was by no means hopeless, changed the whole situation.

It is now generally admitted that tuberculosis infection is almost universal. Dr. Allen K. Krause rates childhood infection as follows: "Beginning with no infection at birth, a very few children become infected by the end of the first year. At the age of two, this has reached 10 per cent.; at four, 25 to 30 per cent.; from five to ten years, about 50 per cent.; and by fifteen, or the age of puberty, from 60 to 75 per cent."[2] Dr. Krause believes that at the age of thirty, nine-tenths of those living a highly organized community life are infected.

Here the difference between tuberculosis infection and tuberculosis disease must be emphasized.[3] Certainly nine-tenths

[2] *Journal of Outdoor Life,* June, 1918.

[3] Dr. Krause says: "It used to be thought that only the sick were infected; now we know that only a few of the infected are sick."

of the population do not die of tuberculosis; what therefore has cured those who have lived to die of something else, or rather what has made it possible for them to withstand the presence of the bacilli and avoid the disease? This is the important question, and, generally speaking, the answer has been that in the resistive power of the individual lies his ability to escape sickness and death. How to avoid infection, how especially to avoid childhood infection, and how to strengthen this resistive power in both sick and well, old and young, has been, aside from scientific research, the principal problem of modern tuberculosis work.

The modes of infection, whether from dried bacilli in dust, or wet bacilli in spray, whether by means of milk from tuberculous cattle, whether from houses previously inhabited by tuberculous patients, or whether only by direct contact with the patient, the length of life of the tubercle bacillus under favorable or unfavorable conditions, and the degree of susceptibility to the disease inherited from tuberculous parents, have all been subjects of vigorous discussion. All observers have, however, agreed that the age at which infection is incurred, the length of time during which the individual has been subjected to it and the degree of vitality possessed by him, are the determining factors in deciding whether or not he will succumb. It is because of the consensus of opinion on these points that the nurse has found herself so important an agent in the tuberculosis campaign.

Bedridden tuberculous patients have for years been cared for by general visiting nurses, but it was not until 1899 that the first attempt in America was made to provide systematic home visiting for the tuberculous as a class. The initial step was not taken by nurses, but by two women medical students in Baltimore, who under the direction of Dr. William Osler followed to their homes the patients coming to the Johns Hopkins dispensary, instructing them in regard to diet, fresh air and the disposal of sputum. This work, though undertaken for the purpose of education and relief, partook largely of the nature of an investigation, and the results proved interesting. The social aspect of the situation was recognized from the first, for the students were instructed to cooperate with the charity organization for relief, and with the board of health in regard to

sanitary conditions. The results of the first year of work were of such a striking nature that the suggestion was made that if nurses could systematically undertake it, bringing their special training to bear upon the practical problems involved, more might be accomplished.

It was not, however, till November, 1903, that the necessary funds were forthcoming, and a nurse took over the work of the medical students, and began a regular system of visiting. A few months previous to this, in the winter of 1902-1903, the value of a special nurse for tuberculosis had been recognized in New York and a nurse was engaged by the Charity Organization, while a little later such work was undertaken by the Vanderbilt Clinic. Special tuberculosis nurses were in 1904 almost simultaneously employed by the Baltimore and the Cleveland visiting nurse associations, each acting without knowledge of the plans of the other.

Everywhere the campaign was hopefully begun. It had been learned that tuberculosis was infectious through the entrance of the tubercle bacillus into the alimentary or respiratory tract, and it seemed a simple matter to tell people how to avoid infection. It had been found that power of resistance to the bacilli was increased by healthful living conditions; therefore it was felt that instruction, and the building of sanitoria where the early cases might be assured of the three fundamentals, fresh air, good food and rest, was all that would be necessary. Great stress was laid on the educational value of the sanitoria. All the arrested cases were expected to go forth as missionaries, not only taking excellent care of themselves, but preaching everywhere the doctrines of prevention which they had learned. It was hoped, therefore, that by the erection of a sufficient number of sanitoria supplemented by the city dispensaries to diagnose cases, and a corps of nurses for home instruction, with quite incidentally a few hospitals for the dying, the campaign, if vigorously pursued, need not necessarily be a long one; and that in a few years tuberculosis would be, if not eradicated, at least greatly diminished.

Over twenty years of such effort have taught us many things. They have taught us that an incalculable number of difficulties, having their roots deep in the social structure of our cities,

towns, and rural communities, enter into the problem. They have taught us that the sanitorium patient does not invariably become a teacher of the doctrines of prevention, but that on a return to unhealthful living conditions, unless very carefully followed up, he, too, often succumbs to a relapse of his own disease, and may prove no better than his neighbor in regard to the care of himself and the protection of others. They have taught us that the hopeless and almost unalterable conditions of poverty produce not only the soil in which tuberculosis flourishes, but also frequently produce a weakness and shiftlessness of character on which it is impossible to graft the intelligent self-sacrifice so necessary if a tuberculous patient is to be harmless at home. They have taught us that isolation of the advanced case is necessary if we are to avoid crop after crop of infection, and that such isolation cannot in many instances be accomplished at home, and last, but by no means least, they have taught us that because childhood infection plays so important a part in the acquisition of the disease in later life, it is to the protection of children that a large proportion of our energy must be directed.

The tuberculosis problem has many elements which present themselves with varying emphasis to different workers in the field. That every social condition which affects the living conditions of the individual also affects the problem cannot be denied, and from out of the mass of effort it is difficult to determine the amount of credit due to any one phase of the movement. Many false starts must be made, and time and money wasted, in such an enterprise. Possibly some day a seemingly simple discovery may enable us to do away with all but one type of effort, or to apply some already used weapon in a way more potent for results. Lord Lister, in working out his great discovery of the theory of antisepsis, merely applied carbolic in a new way. It had already been used for a deodorant in the very wards in which hospital gangrene flourished. Perhaps present-day tuberculosis workers will live to see either the discovery of a vaccine, or the application of some already known principle which will replace the slow and difficult methods of today.

Meanwhile results are cheering. It is stated by the National

Tuberculosis Association that in 1904 the death rate from tuberculosis in the registration area of the United States was 200 per 100,000. In 1921 the death rate has been cut in half and there are but 100 deaths per 100,000, while in communities in which intensive work has been done there is a still better showing. In Framingham, Massachusetts, in the years between 1907 and 1916, the death rate was 122 per hundred thousand, in 1920 it was 65; and among the policy holders of the Metropolitan Life Insurance Company a decline of forty per cent. is reported.

A nurse in entering the tuberculosis field must remember that although her work lies largely with the individual, her problem is a community problem. Though she cheers and nurses the patient, though she procures aid for his destitute family, though she preaches the doctrines of healthful living, she will barely have touched the main issue unless she prevents the spread of infection. Otherwise, from the strictly community point of view she may be doing more harm than good by prolonging the life of a patient and so increasing the length of time during which he is a source of infection.

It is difficult to speak of the menace of the open case without seeming hardness of heart. There is no more pathetic object than the advanced tuberculous patient, or one which should so call forth the tender helpfulness of the nurse. Her sympathy, however, must not allow her to forget her function of protector of the health of the community from infection. From the tuberculosis standpoint the inhabitants of any community may be divided into three groups: those who are well; those who are ill, but for whom there is hope of recovery, or partial recovery; and those who are in an advanced stage of the disease and who provide the principal source of infection. Much as every nurse must long to help the pitiful members of the latter group, it would be false and sentimental economy to do so at the price of drawing from the first group, recruits for the other two. The nurse who stands by the bedside of the dying consumptive, and with quick sympathy asks herself the question, "How can I help this poor soul?" must learn to follow it instantly by the even more important and equally sympathetic one, "How can I save others from a like fate?"

The different stages of the disease naturally form a circle

to which there is no beginning and no end. The pioneers penetrated this circle at a very definite point and began their work with the hopeful case. Seeing the suffering of the later periods, they quite naturally said: "Let us go back of this hopeless stage; let us spend our time on the early cases and cure them before they become advanced. In that way we shall do away with tuberculosis." They forgot that back of the hopeful early case in the vicious circle lay the advanced case, constantly spreading bacilli and infecting more new individuals each year than the workers could possibly reach. Sanitoria were built by states, municipalities and private enterprise, the doors of which were tightly closed against all advanced cases, though in the same community there might not be provision of a single bed for them. The dispensaries also expended their energies on the early cases. Nurses gave what care and instruction they could to the dying, and hurried on to give of their best to the men and women who might hope to recover.

After a few years of work, data and the nurses' own personal experiences sounded the note of alarm. From an economic and community point of view there seemed little use in a vast expenditure of time and money, if so large a percentage of the patients who died at home transmitted their disease to other members of their family. Consistent, systematic precaution against the spread of infection is almost more than can be expected of the great majority of patients, because such care presupposes a high degree of intelligence. With no previous knowledge of the underlying principles of the germ theory, unused to consideration for others, often untrained to habits of personal cleanliness, and living under conditions that make isolation most difficult, how can we expect that instruction, no matter how carefully given, will be rigidly observed? Every nurse has watched one member after another of a family develop suspicious symptoms, and after more or less resistance finally succumb to the disease. Looking back over five years, it is plain that if the ignorant affectionate husband and father could have been removed from the lounge in the kitchen to a hospital bed, the whole sequence of events might have been changed.

Theoretically the doors of almost all general hospitals are closed against tuberculosis. Practically the wards are full of it.

Dr. John B. Hawes, director of the clinic of pulmonary diseases at the Massachusetts General Hospital, tells us that a large percentage of the patients in the medical wards of the Massachusetts General Hospital have some form of tuberculosis, though the majority have been admitted under other diagnosis. If tuberculosis, properly nursed, is no more dangerous than typhoid fever, or pneumonia, both of which are freely admitted to the wards of all hospitals, why should it be excluded? The trend of expert opinion seems to be toward the opening of tuberculosis wards in general hospitals, and by such an arrangement the student nurse as well as the patient and the medical staff would gain.[4] The present method of exclusion certainly works badly from the point of view of the nurses' training. The majority of nurses now graduate from their hospitals either with no experience in the care of tuberculosis or with experience only in the care of the advanced and hopeless case. In consequence their interest is not aroused, and tuberculosis work in any of its forms is often repugnant to them.

If nurses are to take the part that is expected of them in the fight against tuberculosis, the young graduate must know it as she knows other common medical diseases, not merely from lectures and reading, but from actual experience in its care. It is not too much to ask that every nurse should leave her hospital with at least a grounding in this knowledge. She should know, for instance, that tuberculosis is preventable; she should be familiar with the generally accepted views regarding infection, and have a working knowledge of the technique involved in avoiding it; she should understand the prevalence of childhood infections; she should know by actual experience that she can care for a tuberculous patient without danger of infecting herself; and above all she should realize that because she is a nurse she cannot escape a personal responsibility for the tuberculosis problem. These things are not learned from books alone. At present such training implies affiliation with sanatoria and public health nursing organizations, and the educational question is somewhat complicated by the fact that many sani-

[4] Wards in general hospitals for advanced cases of tuberculosis are advocated by the American Medical Association and the American Tuberculosis Association. Dr. Jacobs, *Public Health Nurse,* October, 1921.

toria do not employ trained nurses, but rely for nursing service on former patients, women who under direction frequently do good work but to whom it would be manifestly impossible to entrust the teaching of pupil nurses. Certainly a right attitude toward the importance of tuberculosis will never be instilled into a student body as long as the present ignorance prevails.

Tuberculosis has been called the stray dog of the clinic. It is no less the stray dog of the hospital ward and no course of lectures, however valuable, will ever give it dignity in the eyes of the pupil nurse while she sees it treated as a professional pariah.

Though it may be questioned how far tuberculosis is itself the cause of the poor social conditions which seem to produce it, there is proof enough that everything that prevents normal development is grist for the tuberculosis mill; and bad housing, overwork, low wages, lack of recreation, and all poor conditions of personal, family or community hygiene have had their share in increasing the death rate. In America these things are slowly improving, and on such improvements, with the educated public opinion that lies back of them, must be pinned our hopes for future results.

Other factors also are at work. Perhaps none is more important than the rapidly increasing popular recognition of the value of health education. The modern Health Crusade inaugurated by the National Tuberculosis Association is one of several organized efforts to teach health in the schools. The Crusade has been established in every state, and in several it has become a regular feature of the public school curriculum. We know that in the past children who could glibly rattle off the names of all the bones of the body, daily broke, through ignorance, every law of personal hygiene. Today between three and four million children have become Health Crusaders, and to qualify as such are doing various simple health "chores," such as brushing the teeth, washing before meals, bathing regularly, and sleeping with open windows.[5,6]

Another important factor in prevention is the emphasis now laid on nutrition. Since the greatest danger period is in child-

[5] "Relation of the Tuberculosis Movement to Other Health Activities," David R. Lyman, *American Review of Tuberculosis*, April, 1922.

[6] See also "The Rules of the Game," Part II, Chapter 4, page 328.

hood, and since the undernourished child is most susceptible to infection, there can be little doubt that the excellent nutrition work now being done must eventually affect tuberculosis in no small degree. It has been conservatively estimated that at least 20 per cent. of the school children of the United States are under weight to such an extent as to indicate the probability of malnutrition. If this state of affairs can be remedied through proper feeding, certainly a body blow will have been struck at tuberculosis.

Nurses who have been doing tuberculosis work for even a few years must be struck by a significant change in the type of their patients. Advanced and active cases are now being replaced by the contact case, the suspicious case and the very early case. Unfortunately data regarding the results of this kind of work are not easy to obtain. The undernourished exposed child would probably not in any event have had an immediate breakdown. He would have gone on into young manhood in fair health or until some unusual strain of life so weakened his resistive power that he succumbed. Only the lowered death rate of the next decade will show the value of the work being done, and those now being saved will probably never know that they were ever in danger.

With each successive year new knowledge of tuberculosis is being gained. Studies of various kinds have been made, the most noteworthy up to the present time being the community health and tuberculosis demonstration carried on at Framingham, Massachusetts. This experiment and demonstration was begun in January, 1917, under the supervision of a committee organized by the National Tuberculosis Association, with the general idea of ascertaining what could actually be accomplished in the reduction of tuberculosis in a small American city by adequate and perfectly correlated effort. Framingham, a city of 17,000 people, was selected because it was considered a typical industrial community. The demonstration is not yet finished, but much has already been learned that is applicable to other communities. The fact was early developed that Framingham had in its midst more than nine times as many cases of tuberculosis as were on record, and these figures are believed to be fairly typical of the situation elsewhere. Possibly had a larger

city been chosen for the experiment, findings in regard to methods of work might have been more universally applicable. Possibly also had problems relating exclusively to questions of nursing received more specialized study, a greater knowledge of this aspect of the subject would have resulted. Nevertheless the demonstration is of a very great value for through it two important things have been learned: first, that tuberculosis can be controlled; and second, how to control it;—knowledge that must bring a new spirit of hopefulness to every worker.[7]

The tuberculosis campaign is a long campaign and an expensive one, far longer and far more expensive than anyone dreamed. Dr. Lyman quotes a well-known medical authority who at the beginning of the movement said, that if anyone would give him three million dollars, he would wipe out tuberculosis in one generation. Not long since, the small state of Connecticut appropriated $1,500,000 for two years of tuberculosis work alone.

If tuberculosis is to be wiped out or even brought under control more is needed than mere money. We must have leaders and among them must be nurses capable of bringing to the nursing problems knowledge, experience and judgment. A noble heritage of leadership is ours. Few men have left so deep an influence on any movement for the public good as Edward Livingston Trudeau. His words, "On the spirit of a work like this depends its success," will always be an inspiration to those who follow where he led.

[7] The tuberculosis death rate in Framingham in 1920 was 40 per 100,000, as against an average of about 100 per 100,000 for the United States as a whole. Report of Executive Officer of the National Tuberculosis Association for year ending May, 1922.

Chapter 2

TUBERCULOSIS (CONTINUED)

In writing of tuberculosis as in writing of the other special branches of nursing it is simpler to speak of the work as a unit. This does not imply specialization. The generalized nurse may apply all that is said to her own work, merely eliminating a few paragraphs that deal with the tuberculosis staff as a group.

The duties and responsibilities of a nurse doing tuberculosis work, whether specialized or generalized, fall under certain general heads which may be summarized as follows:—discovery of contact and suspicious cases, with consequent arrangement for diagnosis and treatment; discovery of new positive cases; prevention of the spread of infection; care by instruction or nursing service of those who must remain at home; cooperation with other agencies for the welfare of the patients and the protection of the community; routine duties at clinic, dispensary or fresh air school; public speaking or other publicity work in the cause of tuberculosis prevention; and such record-keeping as is required for local work and for the study of the problem as a whole.

In beginning work a nurse may find that considerable information regarding community conditions has already been secured by means of a survey, or perhaps that a survey is contemplated. The purposes of a survey have been well described by Mr. S. M. Harrison. "Fact gathering," he says, "is the A. B. C. of the survey. It is an attempt in the field of civic and social reform to do what the civil engineer does before he starts to lay out a railroad, what the sanatarian does before he starts a campaign against malaria, what the scientific physician does before he treats a case, what the modern manufacturer does before he locates a new manufacturing plant. It is in short an attempt to substitute tested information for conjecture or mere belief."[1]

[1] "Community Action Through Surveys," Shelby M. Harrison, Director of Department of Surveys and Exhibits, Russell Sage Foundation.

A little opprobrium has of late been attached to surveys because for a time they became so popular that a disproportionate amount of time and money was spent upon them, not infrequently leaving the community purse empty for further effort. They have their place, however, and have been of great value to many communities.

If there has been no survey to reveal the tuberculosis situation, a new nurse should lose no time in acquainting herself with a few fundamental facts. First of all she should know the extent of tuberculosis in her community. To determine this she must know the number of reported deaths and the relation of the tuberculosis death rate to the general death rate (a ten-year period may be used for this study), and she should know the number of living cases reported during the preceding year, though this will probably be far below the number actually existing. She should know whether there are any localities having a persistently high death rate, or any occupation that shows a large mortality. In addition she must early acquaint herself with all existing measures for control; the number of sanatorium and hospital beds available in the state, county, municipality or township, and the relief and other agencies on which she may rely for cooperation. She should also know the attitude of her health department towards tuberculosis, and be familiar with all city ordinances and state legislation which may affect her problem. Possessed of this information she is ready to begin work.

For purposes of tabulation the cases which come under a nurse's care may be grouped as follows:

1. The advanced case.
2. The moderately advanced case.
3. The early case.
4. The suspicious case (the individual who presents symptoms of tuberculosis, but for whom there is no positive diagnosis).
5. The contact case (the individual who is known to have been dangerously exposed. This group is usually composed largely of children).

It is estimated that for every recorded death from tuberculosis there are from eight to ten other people who have the disease. Nurses should not feel that they are covering their community unless they are reaching approximately this number, and, in

addition, are carrying as contact cases those individuals who are known to have been dangerously exposed.[2]

A clever nurse will make use of every channel of information in her effort to discover new cases. Routine examination of the weekly death returns and a visit to each family in which a death from tuberculosis has occurred, will keep up the list of contact and suspicious cases. In many communities such visits are made without reference to the social condition of the family, the rich as well as the poor receiving a call and an offer of assistance and advice. The desirability of this method is now generally recognized, and the nurse is quite universally welcomed. All families are not continued under observation, but the routine procedure works well, particularly when there are children who have been exposed. Every known positive case will also naturally increase the number of contact cases.

In tracing tuberculosis every legitimate clue must be followed, but in so doing a nurse is sometimes confronted with a difficulty. If a case has been diagnosed as positive by reliable authorities and bacilli found in the sputum, a nurse is placed in a most trying situation if the patient transfers his case to another physician who tells him that he is only suffering from bronchitis. Unless absolutely forbidden the house she will do well to continue her visits, giving only general advice, but maintaining her friendship with the family against the day when another turn of the wheel of fortune brings the patient back to the dispensary or to a physician with a different attitude of mind. Quite as difficult is the nurse's path when a physician, after diagnosing a case as positive, refuses to acquaint the family with the real situation. It is absolutely impossible in these circumstances to inaugurate the routine procedure necessary to secure the protection of the patient's family and friends. Again a nurse is forced to await developments, though she may comfort herself with the thought that so great has been the change in the point of view on this subject that the time is not far distant

[2] One hundred per cent. of the cases in any community will probably never be reached by public health nurses. A small number are always cared for by private nurses, others die in general hospitals from acute forms of the disease, while others die immediately on arrival in town, calling a doctor only at the last minute.

when the number of undiagnosed cases, or those from whom the truth is withheld, will be a negligible quantity.

When a case has been diagnosed, and the patient told the nature of his disease, it is often a question how far a nurse's responsibility extends in her effort to safeguard the health of the community from infection. While the patient remains at home the nurse's responsibility cannot be too strongly emphasized, for it is there, where the patient spends the greater part of his time, that the greatest danger lies. Danger from infection is in more or less direct ratio to the length of time to which the individual has been exposed, and for this reason we may safely assert that the home is the principal center of infection, and it is there that the nurse's time and energy must largely be expended.

It is now generally conceded that the advanced case should as a rule be hospitalized, but if this is to be accomplished the hospital must be made attractive and so situated that it will be possible for the family and friends of the patient to see him there. No family will willingly send one of its members to die among strangers, too far from home to be visited. When appropriations are being made for building, it is sometimes possible for nurses at public hearings or elsewhere to set forth the point of view of the poor in this respect. It is not always understood what railroad fares mean, or how little accustomed some people are to even short journeys.

Three methods have been used to induce patients to enter a hospital: coercion, persuasion, and laws allowing the forcible hospitalization of the wilfully careless. It is now felt that coercion by the withdrawal of material relief and nursing care with a view to decreasing the temptation to remain at home is a poor policy. Such measures have rarely had any effect on the patient, and members of the family, left without proper provision, are apt to so deteriorate in health as to become fit subjects for infection. Compulsory segregation has not proved much more successful. Compulsion is a difficult weapon to handle and one that is useless unless backed by public opinion. Compulsory laws also presuppose an adequate number of hospital beds for the dangerous cases, a situation that does not exist everywhere. For every vacant bed there are often a dozen

patients on the waiting list who ought to be put into it, and it is not always the one who would fall under the provisions of such laws who is doing the most harm. A seemingly docile patient who is constantly surrounded by a devoted family and a roomful of friends, may be a greater source of danger than another who openly refuses to take precautions, but who spends his days and nights alone. Laws for compulsory hospitalization, if they are to be effective, must provide in some way for retention of the patient after he has once entered the hospital. Many departments of health, having power under ordinances regarding communicable diseases to send patients to hospitals, have no power to keep them there.

In persuasion, we believe, lies the nurse's greatest power and she must remember in exercising this power, that it is to the friend they find in her that people will turn. Sincerity, in this as in all the other relations of life, must be the foundation on which the desire to serve is built. A true picture of the hospital, with an exact statement regarding visiting days, privileges, etc., should be given, and great patience shown in overcoming a not unnatural fear of the unknown.

The sanatorium presents a simpler problem than the hospital because in the former the nurse can hold out to her patient a surer hope of gain. It must be made clear, however, that to secure this, personal effort on the patient's part will be required. A modern tuberculosis patient is the antithesis of a surgical patient. The latter, as far as the treatment of his disease goes, is possessed merely of a body which he surrenders to a surgeon for operation. The less he knows about the details of his case the better, and during the operation no help is expected of him save the very passive one of remaining unconscious. The tuberculosis patient, on the other hand, must work out his own salvation, and he must be carefully taught how to do it. On his intelligence, his will power, his pluck and his personal knowledge of his disease, he depends for his recovery. Modern doctors no longer issue orders, they act as a teacher; and as in the ordinary education of children we have learned to depend on the school, so in the education of the tuberculous have we learned to depend on the sanatorium. A child can learn at home, if properly taught, but a school with its corps of trained teachers in constant

attendance, its equipment, and the stimulation of other scholars, usually provides a better medium for beginning education. A sanatorium, with its doctors and nurses, its regulated life, its equipment for living out of doors, and the companionship of other patients who must learn the same hard lessons, does the same thing for the patient-student of tuberculosis. If bright, he may learn quickly and be able in a reasonably short time to return to his home and there, supported and stimulated by his clinic visits and the nurse's calls, continue his treatment and education without danger to his family. He will need help, however, for the average man or woman unstimulated by teachers or fellow students, loses ground without these aids.

If rest-fresh-air-and-food could be compounded into a noxious dose, and put in a big black bottle, or if it could be given by inoculation with all the paraphernalia of elaborate surgical procedure, the treatment for tuberculosis, even if prolonged, would be comparatively easy to enforce. It is because the details of the lessons are so familiar that they are so difficult to teach, particularly amid the every-day surroundings of the patient's usual life.

The time has passed, however, when long hours must be spent in persuading a patient to enter a sanatorium. Education has had its effect in popularizing sanatorium treatment, and nurses now find that the majority of their patients are glad to go, provided satisfactory arrangements can be made for those dependent on them. The question to be decided is more often how a patient can go, than why he should go. If he is to leave a family, he must have peace of mind concerning them, and he should not be expected to be content with vague assurances that some hitherto unheard-of agency will probably see that everything is all right.

Little things count in making sanatorium life happy. In arranging for equipment, it is well to see that the usual thing is provided. No one likes to be peculiar, and patients frequently suffer from added homesickness merely because their outfit is unusual.

A nurse doing tuberculosis work will need to keep in close touch with the sanatorium, for she should know whereof she speaks when persuading a patient to accept treatment there. No

untrue picture of a pleasant, care-free, outdoor life should be drawn, which will lead the patient to expect an agreeable summer outing, but rather a true one of the daily routine to be expected. Above all the patient should be made to feel that he enters a sanatorium, not for the purpose of being cured, but in order that he may learn how to cure himself. It is a great help if the nurse can sometimes arrange to visit the sanatorium herself. Not only will she gain by an added familiarity with the conduct of the institution, and a personal acquaintance with its staff, but she will find her relation to her sanatorium patients and their families greatly strengthened. She is needed as a link between the two. If time and money permit, and the sanatorium is not too remote, occasional routine visits are to be recommended.

When a patient returns from a sanatorium, or recovers sufficiently at home to resume his work, he must be carefully watched and a return of any of the old symptoms, rise of temperature, cough, pain in the chest, loss of strength, night-sweats, shortness of breath or rapid pulse, must be reported at once to the doctor. There will usually be a slight loss of weight with the resumption of normal life, but this, too, should be watched for and reported. A period of what has been called industrial convalescence is also to be expected. A patient even when physically well does not pass directly from the abnormal life of invalidism into immediate economic normality.

A large number of the patients on a nurse's visiting list are more or less able to work, and she is continually confronted with the problem of how, and at what, they can work to the least disadvantage to themselves and other people. In the early days of the tuberculosis movement there was a great outcry for outdoor work for the arrested case, and many a good mechanic became a poor gardener or outdoor laborer. Lately it has been felt that as a rule accustomed work, if done under fairly healthy conditions, is better for the patient than outdoor work for which he has neither training nor inclination. Also in his accustomed work he has usually the advantage of better wages, which enables him to maintain higher standards of living. The danger of the tuberculosis employee to others, is of two types,—the danger to the customer or the employer, and the danger to fellow workmen. The most dangerous occupations to consumers

or employers are those that have to do with food or domestic service,—cooking, or handling milk or other foodstuffs taking precedence. Home laundry work if done continuously for the same customers is not safe, but occupations having to do with neither food nor personal service need not be feared. For the fellow workmen the danger naturally depends upon the carefulness of the patient. It is often difficult to persuade a man who is willing to take every precaution at home to carry sputum cups to his work. This is so natural that the nurse can have nothing but sympathy with the desire to avoid conspicuousness or the possible loss of work. She must, however, press the point, and be ready to give whatever help she can to an employer who is willing under proper conditions to retain a tuberculosis employee.

The ethical question as to whether a nurse, knowing that a patient is a menace to an employer or others, ought to give unasked information on the subject, is answered in different ways by different nurses and doctors. The responsibility is certainly a heavy one where a nurse knows that the health of a whole family is being jeopardized by a careless tuberculous cook; or that delicate working girls, whose one asset is their health, are being served by a boarding-house keeper who threatens them with tuberculosis at every meal. The sympathy called forth by the cook and the boarding-house keeper, whose ignorance and carelessness are part of their general make-up, hardly exonerates the silence which has for so long given protection to the sick of this and other diseases, at the expense of the unsuspecting well. On the other hand, a community that insists on its own protection from such evils cannot expect the entire price of protection to be paid by the infected. A man who is deprived of work that he is able to perform, because by performing it he becomes a menace to others, has a right to expect suitable provision for his needs at the hands of the protected community.

Much anxiety has been felt in regard to the infection spread by the homeless man who drifts from lodging house to lodging house, spending perhaps a night or two in each. While it is desirable that the whereabouts of everyone suffering from tuberculosis should be known, these drifters are less dangerous to the community than those who live continuously in one place. They

are, however, pathetic in the extreme, and their removal to a hospital where they can receive care and attention is of course highly desirable.

In the old days tuberculosis was widely spread through the practice of sending patients into the country in the hope of improving their health. This practice has fortunately fallen into disrepute. Indeed doctors nowadays rarely prescribe any complete change of climate, preferring that a patient should recover in the climate in which he must live, thus avoiding a difficult and dangerous period of readjustment.

No effective tuberculosis campaign can be carried on without a free clinic or, at least, some provision for free diagnosis and medical care. It is not only desirable to secure patients in the earliest stage of the disease, but it is also desirable to keep a watchful diagnostic eye on the so-called contact cases, those who, though not ill, have been exposed, and also on those who present suspicious symptoms. Such people, if poor, will rarely consent to pay a doctor's fee for what seems to them a useless precaution.

If, as sometimes happens in pioneer work, employment of a nurse has been the first step taken, her every effort should be directed toward the establishment of a free clinic, for without it she is utterly powerless. This should be done through the medical profession. Nor must she feel that having secured such provision for medical care it is enough merely to be present at the clinic or dispensary. Attendance of the patients at clinics will as a rule prove a very good index to the activity of the nurse for they will be well or ill attended in almost direct ratio to the success of her work in the homes.[3] It is easy for a nurse to grow a little careless about the clinic attendance of her patients and to rely too much on her own exertions in the homes. All old patients should present themselves regularly for examination, and new undiagnosed cases should be constantly brought in.

Though all diagnosis will of course be left to the doctor, every nurse should be familiar with the symptoms of tuberculosis. They have been listed as follows:[4]

[3] The statement presupposes a doctor interested in tuberculosis. No nurse can keep up clinic attendance unless the doctor does his part.

[4] Communication from the Director of National Tuberculosis Association addressed to the American Sanatorium Association.

1. Lassitude[5]
2. Weakness
3. Cough
4. Hoarseness
5. Expectoration
6. Dyspnea
7. Fever
8. Rapid pulse
9. Pain in chest
10. Night sweats
11. Hemoptysis
12. Loss of appetite
13. Nervous instability
14. Underweight, or loss of weight
15. Slow recovery from other diseases

A nurse should also know that the following conditions favor the development of active disease:

1. Pneumonia, pleurisy, measles, whooping cough, influenza, etc.
2. Pregnancy, parturition, lactation
3. Mental and physical strain
4. Unsanitary living or working conditions
5. Injury
6. Dissipation
7. Malnutrition
8. Lack of sleep, especially in children.

The types of the disease at different ages are distributed more or less as follows:

Infants—Generalized; disseminated; acute.
Children—Bones; joints; lymph nodes; meninges.
Adults—Lungs chiefly; skin; kidneys; other tissues; fistula.

For the nurse whose previous experience has been principally along the lines of bedside nursing it is not always easy to assume the teacher's role, but it is on her success as a teacher that her value in tuberculosis work depends, and she must be well grounded in her knowledge. In the past every nurse knew more about tuberculosis than most patients. This is no longer the case. The average tuberculosis patient under proper instruction passes very quickly out of the primary grades and demands advanced teaching. What is more, he knows perfectly well whether or not he is getting it. A comment made upon a new nurse by an intelligent scrub woman may well be heeded: "Yes," she said, "Miss Brown was very nice and kind, but I would rather have someone who could answer my questions. She did not seem to know much about tuberculosis." Lessons must of

[5] Dr. Emerson has said, "Always be suspicious of a loss of 'Pep.'"

course be graded. What is suitable for the beginner is quite unsuitable for the advanced student and *vice versa.*

In visiting a new case a nurse must not allow her zeal to carry her along too fast. It is as unprofitable to try to teach a family all that it is necessary for them to know at the first call as it would be to teach a child the entire alphabet in one lesson. Owing to the nature of the disease there is no need for haste, because a few days more or less will not make any particular difference, and it is far better to build a firm foundation for future teaching, and avoid antagonizing the family, than to lose all by trying to do too much. A nurse new to the work is often rather shocked at the deliberation and caution of the older workers in this respect, but she will do well to take a leaf from their book. She must also remember that the uninstructed family is not able to differentiate between the importance of the various pieces of advice given. She must therefore place her own emphasis by the omission of all unimportant details, until the main principles have been fully grasped. The psychological effect will usually be better if on her first call she dwells principally on such things as make for the patient's comfort and relief, leaving for later calls insistence on less welcome matters.

As a rule a new patient should be visited frequently for the first few weeks, both because instruction is best given in small doses, and because the more quickly a friendly relationship can be established, the better. Everything should be carefully explained, and the nurse must look into all details herself, leaving nothing to chance or the probable intelligence of the family. A liberal expenditure of time at first will often prove a saving in the end. Instructions should include arrangements as to the patient's diet, and regulation of his hours of rest and time spent out of doors. Provision must also be made for his sleeping, if possible, in a room alone, and, certainly, in a bed alone, and the family must be helped to arrange the sick room to the best advantage.[6]

[6] The following rules, arranged by Miss Mary E. Edgecomb for the use of the Providence District Nursing Association, regarding the disposal of sputum and the care of dishes, bed linen, etc., are more or less typical of generally accepted methods:

"See that patient has sputum cups and fillers, or pocket sputum cup.

As the importance of rest for the tuberculosis patient is more strongly emphasized the question of exercise is receiving a far greater attention than formerly. The amount and kind will be decided by the doctor. As a rule none is allowed if there is a rise of temperature or, of course, after hemorrhage. If the patient possesses a fair degree of strength the nurse will have to be very explicit as to what constitutes time spent in the open air. A woman will often report a number of hours spent out of doors, when closer inquiry elicits the fact that she took a closed car at the corner and got out at the door of a crowded department store where she spent two fatiguing hours among the bargain counters, and returned to her home in another closed car. Such a patient will need to be taught with infinite patience that the putting on of a hat and coat and leaving the house is not taking the fresh air treatment.

To dispose of filler, place cup on newspaper, remove filler, drop in newspaper and burn in furnace or stove. When there is no fire in stove, fold in a number of newspapers, place in rubbish burner, soak with kerosene and burn (instruct family never to pour on kerosene after fire is lighted), or dig a hole in the yard, cover the sputum with lime, and bury. Boil tin sputum boxes once a day. If any sputum should by accident be spilled on the floor, it should be wiped up with cloth or newspaper and burned. The floor should be washed with soap and water.

"For a bed patient too weak to use sputum box, leave plenty of paper napkins. Instruct patient to use napkin once and place in a paper bag or cornucopia made of newspaper pinned on the bed within easy reach. Wrap paper bag or cornucopia in newspaper and burn.

"Use separate dishes for patient. After a meal, scrape all food not eaten into a newspaper and burn. Place dishes in a pan of boiling water and boil fifteen minutes, then wash as usual. Keep on separate tray.

"For bed linen, place newspaper on floor of patient's room. As soiled linen is removed from bed, place on newspaper, roll, carry to stove. Place linen in boiler of water and burn newspaper. Boil clothing and linen one-half hour, then wash in usual way.

"Instruct attendants to wash hands thoroughly with soap and running water after any contact with patient or articles contaminated by patient.

"After death of a patient, burn everything in the room no longer useful, newspapers, magazines, fans, etc. Boil bed clothes. Wash floor, bed and paint with hot water and soap. If possible, repaper walls. Leave windows open for several days. Everything in the room that cannot be washed should be placed out of doors in the sun for several days. If patient has been careless, have mattress and pillows sterilized. If impossible, burn. Make family realize the value of soap-and-water cleanliness."

No patient should be allowed to overexert himself, or indeed to go to the limit of his strength. A reserve of resistive power should always be maintained. This is as true of mental and emotional strain as it is of physical strain. It has been said that a tuberculosis patient should never be allowed to do more than seventy-five per cent. of what he is able to do. All exercise and work should be carefully guided, and vocational training or occupational therapy employed only under expert supervision.

An ingenious nurse will find many ways of getting her patients out of doors, pressing into service flat roofs, back yards, tiny porches, and other seemingly impossible places. If, however, none of these open-air spots is to be found, it is better that a patient should sit for a certain number of hours each day well wrapped up at his own open window than that he should take an exhausting walk to a park, or try to get his fresh air about the streets. For some patients, particularly those who have not the resource of reading, enforced idleness is a misery, and the hours spent in "sitting out" seem interminable. The nurse must realize this, and do her best to keep up such a patient's spirits, encouraging the family to do the same. Where occupational therapists are available the nurse's task in this respect will be greatly lightened, and in any event she will do well to acquaint herself sufficiently with this new curative agency to realize its advances and to make what use of its methods she may without special training.

If a patient is not improving, but is obviously losing ground, he should be encouraged to stay in bed. Even if unfortunately he must go to bed at home instead of in a hospital, he will still be more comfortable and less dangerous to others than if permitted to drag himself about the house. The care of a bed-ridden tuberculous patient does not greatly differ from the care of any other bed patient except for the one point of precaution against infection. Bed-sores are a common danger and must be guarded against and owing to the prevalence of night sweats frequent bathing will be necessary. Indigestion is so common an accompaniment of tuberculosis in all of its stages that a nurse must give time and thought to the question of diet. In the last stages, particularly, much suffering may be saved by care on this par-

ticular point. The last days and weeks of the patient's life, if necessarily spent at home, are apt to be hard on the members of his family, and a nurse must do her best to see that overwork and loss of sleep do not so weaken their resistive power that they are an easy prey to infection.

An anxious family often presses a nurse for an answer concerning the probable length of the disease which seems tending toward a fatal termination. She will be too wise and too well trained to commit herself to an answer but it may interest her to know that the length of the disease has been roughly estimated at from eighteen to twenty-two months, with a longer period for the chronic form.[7]

At the death or removal of an advanced case, it is the nurse's duty to superintend the cleaning of the room or rooms which he has occupied. Fumigation, so popular fifteen or twenty years ago, proved in the light of laboratory experiment but a broken reed on which to lean, and has now almost entirely given place to the use of soap and water and sunshine. A thorough housecleaning is, however, of extreme importance and regarding the details of this the nurse should inform the family with the greatest care. Where no municipal steam sterilizer exists, the question of the destruction of such articles as can neither be washed or boiled is a difficult one. In some instances a charity organization may be willing to replace bedding, etc., which the family could not otherwise afford to destroy, but a nurse will need all the common-sense and good judgment with which she has been endowed to attain the maximum of safety with the minimum of financial loss.

We have been slowly learning by costly experience that there is nothing in the world so expensive as inadequate relief for a family suffering from tuberculosis. Unless the general health of those exposed can be kept up, there are sure to be additional cases, and with each case new financial responsibility falls upon the community. The question of relief is variously handled. Sometimes the tuberculosis nurse is looked upon in the light of a social worker, and relief-giving a part of her work. Where this is the case she must fit herself for the duty, but if there is a relief-giving agency in the community it is well to leave

[7] Dr. Ethan Corey, *Public Health Nurse*, July, 1920.

all relief-giving entirely in its hands, merely placing at its disposal all helpful information.[8]

There is one danger for a patient who is likely to recover that is too often overlooked. In the effort to cure him physically he is sometimes allowed to become a moral invalid. Every tuberculosis nurse has had the experience of joyously watching the return to health of a patient on whom every effort has been expended, only to find that when well, nothing could induce him to return to a regular occupation. "Why work when financial assistance is so easily obtainable?" seems to be his attitude of mind. This is most natural, and should be guarded against. Relief when needed must be graciously and generously given, but the patient and his family should be helped to regard it as purely temporary, and encouraged to look forward to the time when it will not be needed.

There has been much controversy over the type of record form desirable for tuberculosis work. The history card is not an easy one to arrange, for tuberculosis is a relapsing disease and one of long duration, involving disturbance of the patient's entire life. A record card is therefore required that will present, without verbal assistance, after perhaps a lapse of ten or more years, a true picture of what the patient's physical and social situation has been.

Record cards for suspicious and contact cases should not be permanently filed without a careful notation of the final diagnosis and disposition of the case. The list of suspicious cases should be a constantly changing one. Cases which go on to positive diagnosis should be so listed, while those which fail to develop more positive symptoms, and have been subjected to no known exposure, should be discharged with instructions to the patient immediately to consult the doctor or call the nurse if he falls below par.

The contact case presents a statistical difficulty. Such cases are automatically acquired in large numbers through the routine visitation of families in which a death has occurred, or where a patient has been removed to a hospital or sanatorium. In some organizations a family history card is used, the family

[8] This policy has recently been questioned on the ground that it is undesirable to allow more than one person to deal with a family.

being counted as a unit. In some each member is separately admitted, with a separate admittance number, and counted as a separate unit. In others the name of the patient who has been removed to hospital or sanatorium remains in the file of active cases, the routine calls paid to the family being entered under his name. On his death some other single member of the family is admitted, the whole family being statistically represented by this one name. (The foregoing applies solely to contact cases. All positive or suspicious cases are considered as units.) While locally either of these methods may answer the purpose, the diversity is unfortunate because statistical comparison is rendered impossible.

A question frequently arises regarding the danger of tuberculosis work to the nurse herself. Years of experience seem to have proved its safety. Tuberculosis nurses have certainly succumbed to the disease, but not in greater numbers than nurses doing other forms of work, and statistics show that under proper conditions the tuberculosis nurse is quite as safe as any other. A woman doing tuberculosis work is, however, no exception to general rules. If she becomes overworked and run down she is as likely as any other individual to revive an old and perhaps unknown infection. Some authorities deny the possibility of adult infection altogether. Others who do not go as far as this are persuaded of its comparative rarity. All are agreed that before the age of twenty the majority of men and women are infected, and that a poor physical condition of any sort may bring about a breakdown. A nurse capable of instructing her patients ought not to need to be told the simple rules of health, but, if it were not human nature, it would be surprising how diverse her preaching and practice often are.

The nurse specializing in tuberculosis work needs perhaps a word of caution. Tuberculosis is a difficult disease to diagnose. Many of the early symptoms are the same as those of other diseases. The specialized nurse should therefore be careful that her vision does not become so warped that she sees only tuberculosis, or possible tuberculosis, everywhere. If she throws away as chaff all information that does not serve to prove tuberculosis infection, she may do harm instead of good to the cause she seeks to advance. She must keep an ever open mind for symp-

toms and bits of family history that will help toward a negative tuberculosis diagnosis, thus clearing the way for some other correct diagnosis.

A word of caution also to the nurse who is doing tuberculosis as part of her general work. Tuberculosis nursing has now acquired a distinct technique of its own, gained by twenty years of experience and constructive thought. If any nurse would prove the advantages of generalization, the standard of her work must be as high as that of the specialized nurse. She must read and she must study, for the knowledge of yesterday is constantly being superseded by the knowledge of today. There is much excellent literature on tuberculosis, both in book and pamphlet form, information regarding which can always be obtained from the National Tuberculosis Association.

Tuberculosis presents no simple problem. It is confined to no class, race, or country. It is no respecter of age or sex. Its victims are to be found in great cities, in small towns, in healthy-looking villages and in the scattered farm houses of lonely districts. It has existed for centuries and to fight it many agencies are required. The tuberculosis nurse must be possessed of courage and devotion of a high order, and must be able to see the work she is doing in such perspective that it will be raised far above the discouraging details on which so much of her time must be spent, to a height where it will appear to her what it truly is, a great work, worthy of a fine devotion.

Chapter 3

CHILD WELFARE

While no effort will be made in this chapter to deal with the question of preservation of infant life except as it touches the work of the public health nurse, we cannot refrain from a brief historical outline of the subject, taken from Dr. Holt's admirable address at the Fourth Annual Meeting of the American Association for the Study and Prevention of Infant Mortality.

In his address Dr. Holt pointed out that the infant problem is as old as the human race, and has merely changed its aspect at different periods of the world's history, and among different races and peoples. Among savages and barbarians it was a question of getting rid of superfluous children when the food supply was limited. Later, among more advanced nations in which the fighting power of the man was the test of his valuation to the state, the weak and deformed, and in some instances and under certain conditions the girl children, were exposed to death, as an economic measure. In other nations, such as Sparta, the vigorous, strong babies, which had been favorably passed upon by a committee and allowed to live, were most carefully reared, with the result that the Spartans became the finest race of their time. In early Rome, the father, not the state, had the power of life and death over the child, an old custom requiring that the new-born baby be placed by the midwife on the ground. If the father desired the child to live, he raised it in his arms invoking the goddess Levana; if not, it was at once exposed to death. One wonders what effect this moment of suspense had upon the helpless mother's condition. Hardly a nervous strain to which we would care to submit our present-day obstetrical patients!

In some places the children were left in the woods, or exposed in certain parts of the cities; in others, drowned; while occasion-

ally their sacrifice became part of a religious rite. The motives, however, for infanticide have everywhere been much the same; famine, poverty, or the promotion of natural efficiency by the elimination of the weak.

After the opening of the Christian era, the church, rather than the state, interested itself in the infant question, and gradually began to assume the care of orphans, and children abandoned by their parents. It was in the sixth century at Trèves that the first cradle, a marble one, was placed outside the door of the church to receive any child that might be placed there. This example was followed by many churches and some hospitals, but the practice of infanticide apparently died hard, for in Rome, as late as the end of the twelfth century, the bodies of so many babies were caught in the fisherman's nets in the Tiber that the heart of Innocent III was moved to pity, and he arranged to have infants received in the Hôpital du Saint-Esprit.

In the early part of the fourteenth century the Hôpital des Innocens was founded in Florence. After this other hospitals opened their doors to babies, but it was not until the seventeenth century that special institutions for foundlings began to come into existence in the various countries. These were almost invariably under the auspices of the church, the state still taking no heed of its babies, though with the foundation of the Society of St. Vincent de Paul in 1638 some influence was brought to bear upon public authorities to make them acknowledge the civil existence of foundlings.

There are no statistics to tell of the infant mortality of those days, but judging by the results of the same conditions on babies at the present time it must have been appalling. It seems to have been an accepted fact during the seventeenth and eighteenth centuries that, of the children born, the greater number should perish in infancy or childhood.

Even royal babies were no exception; Queen Anne left no heir to the throne of England, and yet she bore eighteen or nineteen children, only one of whom survived even to his eleventh year. The historian Gibbon lost six brothers and sisters in infancy. If this was the case where presumably the best knowledge of the time was available, what must it have been with the children of the poor? A French medical journal of 1780 makes the

statement that in France half of the children born died before the end of their second year.[1]

Very gradually the opinion grew that this state of things, so long peacefully accepted, was not inevitable. Philanthropists and doctors, principally the latter, began to question its necessity and to inquire into its causes, and, toward the end of the eighteenth century, even to suggest reforms.

It is hard for us to realize that the introduction of the practice of vaccination should have greatly affected infant mortality, but the writers of the day tell us that smallpox caused the death, before their tenth year, of one-fifth of all the children born, and that a third of all the deaths of children were due to this cause.[2]

With the publication of a little book in 1817 entitled "A Cursory Inquiry into Some of the Causes of Mortality Among Children with a View to Assist in Ameliorating the State of the Rising Generation in Health, Morals and Happiness" began the preaching of the modern gospel, and its author, John Bunnell Davis, may be regarded as a pioneer in this field. He advocated maternal nursing and public dispensaries for children, and he says, "If benevolent ladies could be prevailed upon to form district committees to visit and inspect the health of sick, indigent children, much practical good would result from a medical and moral point of view. By such visitations as these it may be predicted that the instances of mortality among children will be quickly diminished: at the same time that such benevolent females corrected the absurd notions and errors of the poor as to the domestic management of their children."[3]

What have we in these "benevolent females," but the forerunner of the modern child welfare nurse?

The reduction of the death rate following the introduction of vaccination was unfortunately only temporary, for about this time two of the most prejudicial influences against infant life began to make themselves felt, and even to this day affect enormously the infant death rate. One is the rapid growth of

[1] President's Address, Fourth Annual Meeting of the Society for the Study and Prevention of Infant Mortality.

[2] *Ibid.*

[3] *Ibid.*

the modern city with its consequent congestion, the other the employment of women in factories. It is a well-known fact that during the cotton famine in England and the siege of Paris in France, both times of great suffering and a high mortality for adults, the infant death rate fell, for the very simple reason that the mothers stayed at home with their babies.

Many of the important organizations affecting child-life, now common in other countries, originated in France, among them the Crèche or day nursery, the Society for the Protection of Infancy, and a Society for Nursing Mothers. This last society approached the subject from a different viewpoint, and sought to save the child by caring for the mother both before confinement and during the nursing period.

With the recognition of the social aspect of the problem began legislation tending to preserve infant life. The first Acts were directed against the crying evils resulting from the unlicensed boarding out of babies, and later ones against the employment of women in factories, either immediately before, or immediately after, confinement.

Laws against such employment were passed in Switzerland, Hungary, Austria, Belgium, England, Germany, Portugal and Norway in the latter part of the nineteenth century, and in Spain, Sweden and Denmark the first two years of the twentieth.[4]

During the latter half of the nineteenth century also, the question of infant mortality was taken up by various national social science or hygiene societies, and since 1890 national congresses for the special consideration of the subject have multiplied rapidly.

Dr. Holt assigned this very recent awakening to various causes, differing somewhat in different countries. For the world at large, however, he felt that the humanitarian motive has been the strongest, and, in America, the chief motive.

Among the European nations, especially France with its falling birth rate, the economic aspect has perhaps been uppermost. A third influence Dr. Holt believed to lie in the progress made in sanitary science and preventive medicine, by which it has been shown what is possible in hygiene and public health.

[4] President's Address, Fourth Annual Meeting of the Society for the Study and Prevention of Infant Mortality.

The World War, imposing as it did conditions of unprecedented hardship upon the children of almost all of the European countries, effected at the same time a marked change in the general point of view regarding child mortality. As casualty lists increased in length while birth rates decreased, the vital necessity of saving the coming generation became increasingly apparent; while the close relationship of nation to nation among the various allied countries brought about a mutual assistance hitherto unknown. When the signing of the armistice raised the curtain which for four years had obscured actual conditions, and gave opportunity for constructive plans, it was to the children of every nation that all eyes were turned. Nations that had suffered least hastened to offer thei rhelp, sending to those most in need not only money but their best in medical and nursing personnel; and in addition to the systematic feeding of children which had been carried on in various countries since the early years of the war, thoughtful programs for child welfare work were everywhere inaugurated. Such united effort, and the experience gained from dealing with large numbers of children under such widely differing conditions, have undoubtedly greatly accelerated the child welfare movement the world over. Results have been by no means uniform and each country has naturally built on the foundation previously laid, making such adaptations as were necessary to meet individual conditions. Nevertheless a few fundamentals have been generally recognized as essential: namely, a high standard of special education for the physician, a good obstetrical service, prenatal care for the mother, home visiting with instructions both before and after the birth of the baby (special stress to be laid on maternal nursing), a clean milk supply, and for the sick child instant medical attention easily available either in or out of a hospital.

It was estimated in 1914 that there were in the United States over ten and a half million children under the age of five years.[5] Efforts to secure proper care for 11.5 per cent. of the population of the country would be justified, even if this particular eleven and a half per cent. needed no more specialized attention than the other eighty-eight and a half per cent. When, however, it is

[5] Handbook of Federal Statistics of Children, Children's Bureau Publication No. 5.

considered that the death rate for the early years of childhood is very unnecessarily high in comparison with that of older children and adults, the necessity for vigorous action in behalf of young children is apparent. The effectiveness of such effort if properly directed is convincingly proved by the reduction of infant mortality in various parts of this country and also abroad. The infant death rate in England during the five years between 1910-15 was 111 per thousand. During the five following years it was reduced to 90 per thousand. In 1922 it was 77 per thousand.[6]

Statistics for the United States as a whole are unfortunately not available, because the registration area is too small to be safely representative of the entire country, but we can study the results of work in a number of individual cities. The city of New York, where congestion is probably most extreme and the problem of immigration most acute, has succeeded in reducing its death rate encouragingly. In 1880 approximately 288 per thousand of living infants died. In 1923 but 66 per thousand. The last twelve years show the following figures.[7]

1912	105	1918	92
1913	102	1919	82
1914	94	1920	85
1915	88	1921	71
1916	93	1922	75
1917	89	1923	66

These results are more or less typical of every community where well-organized child welfare work has been carried on. In reading statistics of infant mortality it is well also to remember that the death rate by no means represents the whole toll exacted of the child population of the country. Where child mortality is high, it may safely be assumed that many children who do not die are being reared for the struggle of life heavily handicapped by ill health.

In considering the chief causes for sickness among children we again find our old enemies, poverty and ignorance, vigorously

[6] Speech of Minister of Health (Mr. Neville Chamberlin) in submitting the estimates of the Committee of Supplies, June, 1923. Quoted from *The Medical Officer,* July 7, 1923.

[7] Letter from Bureau of Records, New York City.

at work. Poverty is of course a vast economic problem, but its evil effects on the welfare of children can in some instances be reduced by effective measures to combat the second of these foes, ignorance. Two principal lines of work suggest themselves, that which is concerned with better civic, economic and industrial conditions, and that which aims to give instructions to parents regarding the care of the individual child. In planning child welfare work, therefore, account must be taken of the double set of influences affecting childhood, those that affect all the members of a community, though perhaps more obviously the children and those that affect the children alone. To the former group belong many of the civic laws and regulations such as housing laws, sewerage and water regulations, etc. These are important and must not be ignored by any public health nurse, but in the present discussion of the subject only those will be considered that affect the child alone. In any such consideration, however, it must be borne in mind that all individual effort will be unavailing unless town, city and state authorities are on the alert to do their part for community health; and this is no less true of rural health officers than of directors of state or city health departments. In other words, to be successful, child welfare work, in the somewhat restricted sense in which the term is generally used, must be part of a broad health program that will make for the better health of all citizens.

If the work is new, wisdom counsels deliberation, for only one step at a time can be taken. Zeal that demands immediate accomplishment and is impatient of delay in saving child life is to be commended, but it must not be forgotten that child welfare work is essentially an educational work, and therefore of necessity slow. The accepted pedagogical principles apply here as in all other educational work, and if the mothers are to be well taught they must first learn to want to be taught. This awakening of a desire to learn is sure to follow thoughtful and well-considered effort, but it cannot be hurried. In the early days of the child welfare movement a certain city engaged a large body of inexperienced public health nurses to teach child hygiene in the poorer sections of the city during the summer months. Great things were expected, but the ground

had not been tilled nor were the laborers skillful, and the result was a failure. Before the summer was over mother after mother besought the authorities to take the nurses away. A few years later, after the use of slower and more painstaking methods, these same mothers learned to welcome the instruction they had rejected in the earlier experiment. When this lesson is learned there is no limit to the results that can be obtained, and to gain such cooperation any desire for brilliant early results or telling statistical records may well be sacrificed.

Before starting work in a new place it is well to know, if possible, a few of the actual conditions existing in the community. To those unused to gathering such information the task is apt to be associated with that modern word "survey," which suggests a somewhat formidable undertaking. The securing and tabulation of this information may indeed be very scientifically conducted by an expert who will not only present a detailed and accurate report of conditions, but also a full plan of campaign. Expert assistance is often well worth paying for, but it is by no means a necessity for the average community. In reality it is a very easy matter to find out a few fundamental facts about the general health situation in any city or township, and such information can be added to as work proceeds. This first simple study may be made by anyone possessed of intelligence and sufficient interest to devote a little time to it.

Before, however, giving the outline of an elementary study that could be carried out in any community, more than passing mention must be made of the vital importance of birth registration, for it is the foundation on which all work for children rests. Birth registration means "the record in public archives of the births of children." Unfortunately the United States is far behind the civilized countries of Europe in a general recognition of the importance of such records. Some of the states have good laws properly enforced; but where public opinion lags, state laws are usually found to be inadequate, thereby making accurate statistics for the country as a whole impossible. Yet any serious study of vital statistics must be based on a precise knowledge of the number of individuals born. An American is often mortified in reading reports of world-wide comparative statistics to find those of his own country omitted, with the

statement that United States statistics are "not available." Apart from the academic interest of such statistics and their usefulness in studying and dealing with actual conditions, particularly those affecting child life and infant mortality, work with the individual child is greatly facilitated by a prompt and accurate system of birth registration.

The following outline for a simple study of community conditions and existing provisions for child welfare work can be made with the expenditure of very little time, and will repay the efforts of those who undertake it. Volunteer help can be used to advantage in securing the information, and the work will prove educative if intelligently done. Perhaps it may not be amiss to suggest to the novice that considerable tact is required for this kind of work. If the general attitude assumed is one of criticism, antagonism is sure to be encountered and will prove a serious hindrance to future effort. A frank and sympathetic expression of interest will usually clear the way for helpful interviews.

Simple Study of Community Conditions

1. Statistics.
   - *a.* Birth registration. Find out from the health officer if the law requiring birth registration is enforced. Birth registration tests may be made by means of house to house canvassing, investigation of selected lists of births, or display of lists of registered children. Such tests require the backing of a carefully selected committee.
   - *b.* Infant mortality rate. Find out the number of deaths of children under one year of age during the last calendar year. For statistical purposes the infant mortality rate is reckoned on the basis of the number of deaths of babies under one year of age per 1,000 live births a year. Even though the annual birth rate of a community does not reach 1,000 live births a year the birth rate is still reckoned on the same basis. Stillbirths are not, unfortunately, as a rule taken into account.
   - *c.* Classification of infant deaths, as to cause. This may be done on very broad lines; such for instance as ascertaining the number of deaths from diarrheal diseases, from respiratory diseases and from diseases of the first few days.
   - *d.* Percentage of cases attended by midwives. This, because babies whose mothers have not been attended by a physician, present

a somewhat different problem from those attended by physicians.

2. Existing provisions for child welfare work.
   a. Public health or visiting nurses. (Number of nurses and amount of time and attention given to children.)
   b. Prenatal care of expectant mothers. (Whether through prenatal clinics, home visiting by nurses, mothers' classes or advice from private physicians.)
   c. Obstetrical care at time of confinement. (Whether in hospitals, or by doctors at home. Provision for organized nursing service.)
   d. Hospital care for sick babies and children. (For contagious and non-contagious cases; sanatoria provision for tuberculous children.)
   e. Supervision of midwife cases. (If midwives are licensed or instructed.)
   f. Supervision of boarded out children. (If women boarding children require a license for the exact number of children boarded; also age limit of children for whom license must be obtained.)
   g. Supervision of day nurseries. (If work for mothers of young children is discouraged, when possible, by day nursery.)

3. Civic conditions.
   a. Health department. Amount per capita spent for health department in comparison to amount spent for other objects and to amount spent by other cities, towns or counties of same relative size. Is there a child hygiene department? Are physicians or nurses employed by the health department? Educational work of health department.
   b. Other health activities of private agencies.
   c. Special local health problems. (Malaria, hookworm disease, etc. Means of dealing with these.)
   d. Water supply.
   e. Milk supply. (Special reference to poorer parts of the city.)
   f. Sewage disposal.
   g. Garbage disposal.

4. State child labor laws.

5. State laws regarding work of women immediately before and after confinement.

Medical and nursing work may be considered from several angles: from the angle of the individual, from the educational angle, or from the angle of the research worker. All are important, all are more or less interdependent, and in many types of activity all three phases are represented. A children's clinic, for instance, deals with the individual child, serves as a means of instruction for medical students and nurses, and furnishes data from which research work may be carried on. Public health nurses should be interested in all these aspects of their subject, recognizing the importance of training others to follow in their footsteps and the value of collecting such data as may be advantageously studied. It is, however, in the care of the individual child that the major part of the time of a nurse will be spent.

Local conditions rightly exercise a powerful influence in determining the methods of work to be employed. But the needs of a child vary but little with locality, because they represent the primal necessities of life, and the problem whether in the North, South, East or West, in town or country, usually resolves itself into a question of obtaining these primal necessities. In addition to normal parents, a child, for perfect health requires that his mother should not be overworked, underfed or overstrained nervously before he is born; that she should receive a medical supervision during pregnancy that will prevent accident; that she should have proper care at the time of his birth; that she should have sufficient breast milk for him; that he should be kept clean and suitably clothed; and that he should live in a house adapted to his need of fresh air and warmth. As he grows older he needs proper food, provision for play, and wise training in habits of mental and physical health. Throughout infancy and childhood he requires the protective care of both of his parents. Failing any of these requisites to perfect health, and social and economic conditions deprive very many children of one or more of them, the next best thing must be provided for him.

Here is where a public health nurse steps in, but in doing so she must keep a clear vision. The provision of clean milk, properly modified for the baby whose mother cannot feed him in the natural way, is good, but the cause of this inability on his

mother's part must not be lost sight of. If the failure is due to overwork during the natural period of lactation, or to work away from home, effort to secure better conditions for infancy should not cease with the provision of clean milk and instruction as to its modification. The community that provides nurses who find and bring to medical attention the children requiring surgical interference for deformities is performing a valuable service, but the community that prevents these deformities by the provision of skillful obstetrical care for all of its mothers performs a better one. And so through all the list of child welfare activities. A healthy father and mother, able to make the kind of home in which their children will grow to a healthy maturity, is the natural provision for childhood. Let no worker for child welfare think to better this provision, or allow alleviative measures so to occupy her thoughts that she will cease to protest against the anomaly of a working mother of young children, a dangerously overcrowded tenement, or any other unnatural condition, even though so much time must be spent in dealing with the results of such conditions.

The school child will be discussed in a later chapter. Under the heading, therefore, of child welfare only those activities are considered that care for children up to school age. Though the care of a child should be continuous from an early date in his mother's pregnancy to the day that he is turned over to the school nurse, we may for convenience of discussion divide his life into four periods, and consider under these headings the services that he will require of a nurse during each period. The following list of services contains those generally accepted as desirable for a well-balanced child welfare program.

1. Prenatal care.
    a. Prenatal clinics.
    b. Prenatal visits in the home.
    c. Prenatal classes.
2. Care at birth.
    a. Obstetrical care of mother at confinement.
    b. Care of mother during puerperium, and care of baby during first two weeks.
3. Care of baby until two years of age.
    a. Routine home visits.
    b. Well babies consultations, or mothers' conferences.

c. Mothers classes or clubs.
d. Supervision of midwife cases.
e. Supervision of homes for boarded babies.
f. Milk stations (if needed).

4. Care of children over two years until school age.
   a. Routine supervision of delicate children (pre-tuberculous, rachitic, heart cases, orthopedic cases, cases of malnutrition, mental and nervous cases).
   b. Children's clinics.
   c. Nutrition classes, posture classes, behavior clinics.
   d. Provision for home care of contagious cases for which there is no hospital accommodation.
   e. Arrangements for treatment of adenoids, enlarged tonsils, eyes, ears or teeth and orthopedic or other conditions requiring surgery.
   f. Summer outing work.

Let us consider in the following chapter some of the details of such a service.

Chapter 4

CHILD WELFARE (CONTINUED)

Statistics compiled by the Children's Bureau in 1911 show that of the children that lived but one week after birth, eighty-three per cent. died of conditions existing before they were born, or of accidents occurring at birth. Such facts clearly show that any scheme having for its object the reduction of infant mortality must concern itself quite as much with the baby before he is born as with the baby after he is born. Nor is it alone a question of mortality. As we know, the child who died is multiplied many times by the children who barely survive birth and early infancy; and a sick child is not only a source of sorrow and disappointment to its parents, but a heavy financial burden to them. This burden is also borne by the community that strives, often ineffectually, to undo the consequences of earlier neglect. Nor must it be forgotten that the welfare of a child cannot be separated from that of its mother. The two are inseparable. Healthy children are not born of women ill-nourished and overworked before their birth. Children whose mothers die in confinement have a lessened chance of life as well as of happiness, and children whose mothers are physically unable to nurse them succumb to disease in far greater numbers than the breast-fed children.

The object of prenatal care may be definitely stated. It is to provide against the dangers of pregnancy and childbirth, to keep the prospective mother in good physical and nervous condition, in order that her child may develop normally, and to so instruct her that she will be prepared to give intelligent care to her baby after it is born. To accomplish these ends ideally, a good medical and nursing service is required, available for all mothers; there must be hospital accommodation for normal confinements, when desirable for social or economic reasons, and for all essential major surgery. There is also necessary

such cooperation of philanthropic and civic agencies as will make it possible for every mother to perform the duties of motherhood satisfactorily. Though few communities are fully equipped to meet these requirements, great strides have been made toward such an accomplishment during the last ten years.

The Maternity Center Association of New York in describing its admirable system of supervision during pregnancy places emphasis on four points: first, the nurse's visits to the home; second, the patient's visits to the nurse at the center; third, the patient's visits to the doctor at the center; fourth, the patient's visits to the center for group instruction. The following reasons are given: "Visits to the patient in her home are made because the patient must be cared for and advised in relation to her family and environment. The patient's visits to the nurse help to make the patient realize her responsibility for the care of herself and her baby, and reduce the cost of that care by reducing the time spent in travel by the nurse. The patient's visits to the doctor at the center make possible medical supervision for those patients who will be delivered by midwives, and those who delay engaging their own doctor or registering at a hospital. Group instruction provides the contact with other mothers and stimulates discussion which makes teaching more effective and less costly."

A prenatal case should be seen by the nurse at frequent intervals, every two weeks up to the seventh month is a usual procedure, and every week thereafter till confinement, unless the patient is visiting her doctor or the clinic regularly, in which case periods between visits may be lengthened. The abnormal case always presents an individual situation. No routine can be advocated, but every such case must be closely watched and seen as often as required. Though the frequency of home visits will depend upon the other opportunities for working with the mother, they should in no case be wholly omitted, and a first visit to the home early in the conduct of the case should be made a matter of routine.[1] Each visit must be part of a carefully planned scheme to carry the mother along, step by step, until at the termination of pregnancy she is not

[1] From an economic standpoint the desirability of home visitation for prenatal cases is frequently questioned because of the high percentage of not-at-home visits.

only physically competent, but in possession of all the helpful information she is capable of absorbing. A few central facts may well be dwelt upon at every interview: such, for instance, as that motherhood is a natural process and should be a normal one; that it is the duty of every parent to bring their children into the world in good physical condition, and that to do this it is necessary to obey certain recognized laws; that preparation should be made early; etc., etc. More will be accomplished if the confidence of the husband as well as that of the wife can be gained, for in many foreign homes it is he who is the arbiter of fate.

A simple routine urinalysis done by the nurse is now usually considered part of every complete nursing visit, as is also taking the blood pressure (systolic), though in these matters a nurse must be guided by the wishes of the physician in charge of the case. Most doctors, however, are very glad to have these necessary pieces of routine work performed for them. At the first visit every effort should be made to induce the patient to place herself under the care of a physician.

Advice should be given on the following points:

Probable date of confinement and arrangements for confinement.
Diet.
Clothing.
Sleep and rest.
Exercise.
Drinking sufficient water.
Avoidance of heavy lifting and reaching.
Avoidance of worry.
Care of the bowels, skin, breasts, teeth.
Arrangement of room for confinement if it is to be at home.
Articles necessary.
Baby clothes.

If conditions exist that are distinctly prejudicial to a safe pregnancy and confinement, such as financial necessity for continued work in factory or shop or inability to secure sufficient nourishment, it is the responsibility of the nurse to do what she can to change these conditions. Inquiry concerning the following symptoms must not be omitted even though the case may seem normal.

Serious or persistent vomiting.
Repeated headache.
Dizziness.
Puffiness about the face or hands or edema of the ankles.
Blurring of vision or spots before the eyes.
Neuralgic pains.
Muscular twitching.
Tendency to miscarriage.
Abnormal nervous symptoms.

Report will of course be made of any abnormal symptoms, if a doctor is in charge of the case. If not, the patient should be informed that all is not going well, and renewed effort made to induce her to place herself under the care of a physician. The husband should also be informed of the situation.

So much of the success of prenatal work depends on the personality of the nurse that we cannot emphasize too strongly the necessity of bringing to every home she enters an atmosphere of hope, courage, tranquillity and security, factors as potent for health as the physical conditions with which she avowedly deals.

A nurse will naturally be present at all prenatal clinics unless other arrangements are made for nursing service. There was for a time a difference of opinion regarding the clinic attendance of women employing midwives, and it is indeed an anomaly that a patient after receiving scientific care during the period of pregnancy should at the moment of her greatest need be turned over to an unscientific and often careless woman for delivery. It is now felt, however, that so much is gained by prenatal supervision that it is unwise to limit the service to those only who employ a doctor, and in many places effort is made to induce the midwives to send or bring their patients to the prenatal clinic, thus facilitating the discovery of abnormal cases. It may be said also that the establishment of good prenatal work eventually leads to a demand for better obstetrical service, and it has been found that the poorer midwives do not flourish where active prenatal clinics exist. There should be no exclusion of the unmarried mother.

The prenatal club or class at which definite and systematic group teaching is given in a series of lessons, with a quiz at the end, is a somewhat late development of prenatal work but one

that is proving exceedingly successful. The plan has been so well developed at the Maternity Center Association in New York that a brief description of the methods used may prove helpful.

The mothers meet in a room arranged as attractively and informally as possible, where every effort is made to secure a pleasant social atmosphere. They are introduced to each other, the patient's own nurse being present to do this until they become acquainted. Some one (a volunteer if possible) takes care of the children that must be brought, thus freeing the mothers from distraction and relieving them of care. The talks do not exceed twenty minutes in length, and at their conclusion cocoa or lemonade and cookies are served. A model exhibit is displayed and explained and appropriate literature distributed. Stress is laid upon the importance of regular attendance at the whole series rather than on a large attendance at any one meeting. The talks are eight in number with a quiz at the end and deal with the following subjects:[2]

Talk 1. Prenatal care.
Talk 2. Nutrition of the pregnant and nursing mother.
Talk 3. Clothes for the pregnant mother.
Talk 4. The baby clothes.
Talk 5. The baby's toilet tray, etc.
Talk 6. Demonstration of the baby's bath.
Talk 7. Preparation for delivery.
Talk 8. After care.
Talk 9. Quiz.

The best prenatal work, however, may prove useless unless suitable provision can be made for the patient at the time of confinement. Three obstacles stand in the way of such provision: ignorance of the general public and of the individual patient that skilled care is necessary; inaccessibility of such care; and inability to pay for it even if available. The first obstacle, the ignorance of the public and of the mothers themselves regarding the whole question of obstetrics, is not unnatural. A sufficient number of women bear children easily and safely to create a

[2] "Routines and Brief for Mother's Club Talks," pamphlet issued by the Maternity Center Association, New York.

general impression that childbirth is a natural process at which anyone may assist, and for which skilled service is unnecessary. As a matter of fact, childbirth may be the simplest of natural processes or it may involve a critical major operation or a grave physical illness. Careful diagnosis, based on the latest scientific methods, is required to determine to which class each case belongs. The second obstacle, the inaccessibility of the rural mother to medical assistance, is a serious difficulty and one that must ultimately be met in some way. The third difficulty is an economic one, and like all economic problems, full of complexity.

The advantages of home *versus* hospital care for obstetrical cases has long been a matter of discussion. It seems to be the consensus of opinion that both are needed. Hospital accommodation is essential for the abnormal case, but any provision that ignores the fact that many women must be confined at home is incomplete; and unless an organized service is provided there will always be a large body of women who, because of ignorance or poverty, neglect to make preliminary arrangements for their confinement, and at the last moment call in a midwife or rely on the assistance of a neighbor or friend. Public health nurses frequently enlist the free services of young doctors for these patients, but such an arrangement is never satisfactory. Obstetrical care should not depend on a small group of obliging physicians who, in spite of personal sacrifice, rarely meet the real need effectively. A municipal service of doctors and nurses in a districted city, operating from health centers, is one of the ways suggested of solving the problem in the city; with county provision for rural districts, home service to be supplemented by city and county hospital care.

Provision for the presence of a nurse at time of delivery is always a matter of some difficulty, though there can be no doubt about its desirability. Unfortunately the nature of the work, the uncertain date, the uncertain hour, and the length of time consumed at each case make this form of work so expensive that many organizations, perhaps the majority, have found it financially impossible. Where undertaken, it may be done by the regular staff, or special nurses may be set apart for obstetrical service. Under the former system night work is taken

in rotation by the staff, the nurses working an average of forty-eight hours during the week. The interrupted day work of the nurse who has been called out at night is carried on by other nurses. Situations in rural districts, or where a single nurse is employed, must be dealt with individually, though too great sacrifice of other work cannot be made for this service. The rule is usual in most organizations that the nurses go to the house only after the doctor has been called, and that if he finds it unnecessary to stay she too should leave. This is done to conserve the time of the nurse and keep down the expense of the service, but all are agreed that it is an unfortunate necessity, for a nurse's presence during the last trying hours of waiting is of great comfort to the patient.

It is unnecessary to dwell upon the technique of public health delivery work. It does not differ in essentials from the ordinary routine of hospital or private practice. Let us hope that the future has in store for us a better solution of the problem of the delivery service than the past has produced, for through such a service the doctor gains an able and trained assistant with whose aid he can do his best work, and the patient gains physical and mental support and comfort at a time when she most wants them. Moreover, a delivery service increases the demand for prenatal supervision, thus securing for the patients a greater degree of safety.

When nursing care at delivery is impossible, only *post partum* care is given, each obstetrical case being visited as early after confinement as possible. Daily visits are usual for the first eight or ten days, and the baby is cared for till the umbilicus is completely healed. An abnormal case requires a longer period of care, and if hospitalization is out of the question may need two or even three visits a day. Asepsis of a high order as far as essentials go is quite possible in public health work, and should be carefully observed. The opportunities for teaching offered by the *post partum* period must not be ignored. If in caring for the baby the bath is given in the mother's room, much may be learned by the daily repetition of the process. In cold weather this is not always possible, but no case should be discharged until the mother has been fully instructed in all the details of the care of her baby, and arrangements made if pos-

sible for continued oversight. Where the budget of the organization does not permit of routine supervision of all babies, the mother must be made to understand the importance of early attention to apparently small difficulties, and printed or written instructions should be left telling her exactly how to reach the nurse in case of need.

Systematic home visiting of the mothers of young children has perhaps proved the most effective weapon against infant mortality, and it is safe to say that any community can reduce its death rate materially by furnishing such a service for all its babies. Two things, however, are necessary to the accomplishment of this purpose: Nurses who know the technique of child welfare work, and a staff large enough to ensure sufficient time for each baby. Every nursing organization cares for sick babies, and the majority try to do instructive work with the mothers of well babies also, but in the cities of even moderate size the volume of work involved makes a really complete program of this sort extremely difficult; and few communities reach the ideal of adequate care for all. It is a question, therefore, whether it is better to care intensively for a few children or to give less intensive care to a greater number. Some authorities advocate dividing the resources of a community, and concentrating postnatal effort on babies who have not had the benefit of prenatal care. Others feel that a perfect piece of work for fewer children will in the end bring about the better result by proving the necessity of a like provision for all. Thoughtful consideration should determine the policy of each organization on this point, and once determined the nurse must follow the prescribed course to the best of her ability, and not allow herself to be made too unhappy by the limitations imposed upon her. As in all public health nursing work, cooperation plays an important part, and time may often be saved by a division of labor.

Every baby will require a strict individualization, for no two are alike, but, as a matter of routine, instruction on the following points should be given:

Care of the mother's health as it affects the nursing child.
Regularity of feeding.
Supplementary feedings when necessary.

Methods of avoiding loss of breast milk.
Weaning the baby.
Modification of milk for artificially fed babies.
Proper clothing.
Healthful habits.
Bath.
Fresh air.
Sleep (amount and sleeping alone).
Drinking sufficient water.
Bowels (observation of stools).
Weight.

It is impossible to prescribe a routine for the frequency of visits to the sick or very delicate baby. The exigency of each case must be met to the best of a nurse's ability. Though not by any means ideal, the usual procedure for the well child is a monthly visit to the home. Periods between visits may be lengthened if the mother is regular in her attedance at a mothers' conference. Demonstration is the best means of instruction, and in teaching milk modification a nurse must not consider her instruction complete until the mother has herself successfully made up the formula.

Clinics for sick children are usually maintained as part of the activity of a hospital out-patient department, and are as a rule held at the hospital, though not necessarily, as branch clinics may be established wherever needed. Clinics are also maintained without hospital relationship, though the former method is safest, as permanency is secured through the relations of the medical attendant to the hospital staff, and also because the advantages of other medical and surgical clinics are more easily available. The attendance at a clinic of a public health nurse who is familiar with the home conditions of the children is of great assistance. Her time, however, should not be spent in writing record cards, or in other work that could be equally well done by some one possessed of less specialized value. The real value to the clinic of the presence of a public health nurse lies in her power to assist the doctor by her knowledge of home conditions, and in her power to see that his orders are followed out in the home. She will also stimulate attendance, particularly among the slightly ill children and those suffering from diseases the earlier symptoms of which are not readily recognized as

serious. A nurse when making use of a free clinic for her patients will naturally observe the usual rules of professional etiquette and will not send to it children who are already under the care of other doctors, or whose parents are able to afford a private physician.

The well babies consultation, child welfare station, or mothers' conference (the terms are interchangeable) has grown to be one of the most valued agencies in child welfare work. Though outwardly having much in common with a clinic for sick children, there are many points of difference both as to policy and detail of administration. Consultations are held for the purpose of keeping babies well through routine examination of the child and instruction of the mother, and regular attendance is of first importance. In the beginning more education and more careful follow-up work is required to induce mothers to bring their well, or merely delicate, children to a consultation for examination and advice, than is needed to induce them to bring an obviously sick child to a clinic for what is often represented in the mother's mind as "medicine." A consultation usually grows slowly, and regularity of attendance is at first hard to attain. If properly conducted, however, success is sure to follow the first few years of effort.

Almost any agency may undertake the establishment of consultations, provided the cooperation of responsible doctors and nurses is assured. There is a growing tendency for city and county boards of health to assume this responsibility, either wholly or in part. Elaborate arrangements are sometimes made for the housing of mothers' conferences; but though a waiting room, an examining room, and a room in which cases suspected of contagion can wait apart are all desirable, the only real essentials are a good doctor and nurse who understand babies, a mother, a baby and a room to meet in. Schoolhouses are often used, and answer the purpose very well, except for the necessity of holding the consultations outside of school hours or on Saturdays. Consultations should be held every week, on the same day and at the same hour. In congested districts more frequent consultations may be necessary in order to avoid overcrowding. The success of a consultation will depend on meeting the needs of the neighborhood. A Saturday

afternoon consultation that is well attended in some mill districts is valueless in a Jewish neighborhood. If the doctor is regular and prompt in his attendance and the nurse is active in her home visiting, regularity of attendance may be expected of the mothers. Where attendance is large the mothers may be divided into two groups, each group coming to the consultation only on alternate weeks, though for some babies routine weekly attendance will always be necessary.

The question of professional etiquette plays an important part in the early days of the establishment of a well babies consultation. There are few doctors who care to watch the development of a baby week by week, and there are still fewer mothers who would consider paying for such care or who would indeed be able to do so, but if the child is sick the family physician expects to be called. As well babies consultations are not intended for sick children, it is usual to refer all those who are ill to their family physician, or to a clinic if the family is unable to afford a doctor. Difficulties sometimes arise, however, as to what constitutes a sick baby, and what part a well babies consultation should take in the care of nutritional disturbances. Efforts have been made to solve this frequently difficult problem by limiting the types of cases cared for. The following set of rules for the conduct of consultations is more or less typical of those usually observed:

1. Free consultations for babies are established for babies needing prophylactic care or advice.
2. Children under two years of age will be admitted. (If the age limit is two, other provision should be made for older children; if no such provision is made the age limit should be advanced.)
3. Nutritional disturbances will be cared for.
4. Simple remedies, such as local applications or internal medication, like Castor-oil, may be prescribed by the attending physician.
5. Children otherwise sick will not be attended.

The privileges of a consultation should not be limited to children requiring artificial feeding. Breast-fed babies should be equally welcome. Nor should there be any discrimination against the illegitimate child. Literature, if possible in the language of the neighborhood, emphasizing a few simple rules of child hygiene or dealing with such subjects as the care of

milk or the fly danger, should be on hand for distribution. If the mothers cannot read, their husbands are usually able to do so. (Such leaflets can often be obtained free of state or city boards of health.) An educational exhibit, changed from time to time, is also helpful. In addition to the usual record system, weight charts should be so kept as to enable the mother and father, as well as the doctor and nurse, to follow the weight of the child.

As every cloud has a silver lining, so conversely every blessing seems to have its drawback. As clinics and conferences have become more popular, and as mothers have sought their benefits in increasing numbers, overcrowding has become a serious problem. A crowded, heated room filled with children who may or may not be sick, is certainly not a desirable place for a baby. An effort is now being made to surmount the difficulty by conducting clinics and conferences on the appointment system. Where tried, it seems to work well, but a longer experience will be necessary before it is known whether the careless, shiftless mother can be brought to keep her appointments or whether she will merely try to do so for a time and then drift away, leaving to the consultation only the higher type of mother who perhaps needs its service less.

Milk stations are sometimes established in connection with well babies consultations in cities where it is difficult for the poor to buy good milk in their own neighborhood, but they are unnecessary if clean milk can be secured through the ordinary channels of trade. A milk station, if established, must be carefully watched to see that it really serves the purpose for which it is intended. Neighborhoods often outgrow their need for milk stations and when this is so the stations should be closed. They are rarely required in small towns and they are not feasible in rural districts, but it does not follow that either the small town or the rural district escapes the milk problem for babies. Quite as poor milk is sold in a small town as can be found in the most congested district of a large city and a campaign for the supply of the pure article is quite as necessary. Fortunately breast feeding is the general rule in the country, but if a country baby must be artificially fed the question of properly cooling and

keeping the milk is often a difficult one and every rural nurse should be familiar with the principles involved.[3]

In addition to the mothers' conferences at which a doctor is present or in communities where a doctor is not available, mothers' clubs or classes may be formed at which the nurse gives a series of talks on the care of babies and young children. The talk itself should always be brief enough to allow ample time for questions from the audience, the answering of which will usually prove the most helpful part of the meeting. Time should also be allowed for the women later to gather about the speaker for the questions that the timid are afraid to ask from their seats. Especially arranged meetings for fathers are usually well attended.

It is perhaps natural that child welfare agencies should have attacked the problem of child preservation at the point of gravest danger. Because babies die in greater numbers than older children the earliest efforts were directed against influences prejudicial to infant life, but such activity, taken in connection with school medical examination, created at first a curious situation for the average child. As a baby he received constant care and attention from baby consultation doctors and nurses. As a school child he received a like attention from school doctors and nurses. Between these ages his health apparently created no interest at all unless he was actually ill. In many households, therefore, Thomas at the age of three was no one's responsibility, although his baby brother Richard and his school-boy brother, Henry, were both receiving organized health supervision. The doors of a well babies consultation are frequently closed to a child of three, not because his needs are unrecognized but because room for the new babies whose requirements are so obvious, can only be secured by an automatic discharge of older children.

Each step taken in the care of a child makes all succeeding steps simpler. If a baby receives good prenatal care he will be a stronger baby; if he is watched over in infancy he will enter childhood better equipped to meet its dangers; and the

[3] Pasteurization is now generally advocated for all milk other than certified milk. In regard to certified milk, there is a difference of opinion. The approved method of pasteurization is bringing the milk to 145° F., and holding it at that temperature for from twenty to thirty minutes.

same holds true of the period preceding school life. If this can be carefully guarded, school health records will show fewer physical defects. While it is true that the child of two withstands illness more successfully than a baby it is absurd to assume that the automatic passing of any birthday brings with it immunity from disease, and though certain dangers pass with babyhood, the early years of childhood bring with them their own special difficulties. The sequelæ of contagious diseases have left many a child unnecessarily handicapped for life; orthopedic troubles, many of which are undoubtedly treated surgically with the best results before school age, escape the notice of ignorant parents, adenoids and enlarged tonsils need not await school examination for remedy, the results of rickets require early treatment but do not impress the parents as important, tuberculosis and syphilis, most insidious of foes, have gained an unnecessary headway if not discovered until school age, the evil effects of a persistently faulty diet administered for five or six years are not to be easily remedied even at early school age, while unrecognized mental and nervous troubles have ample time to establish themselves before a child receives his first health examination at school.

No new machinery is required for the care of such children. The same mothers' conferences may easily extend their activity by opening their doors monthly to older children. By augmentation of their staff the same nurses may continue to visit their "old babies" at increased intervals, discharging them at five or six into the hands of a school nurse instead of releasing them from all supervision at the age of two. The feasibility of an extension of usefulness is in reality merely a question of funds, for but little additional education is needed to induce the majority of mothers to welcome a longer period of supervision for their children. In all work for older children the friendship and cooperation of the child himself must be sought, and self-control, as well as self-help dwelt upon in such a way as to make them interesting.

Day nursery children should receive systematic routine medical supervision, from both doctors and nurses, of a type similar to that given the school child. The nursery school which in England has been incorporated into the regular school system,

is less well known in America, but is proving an interesting development in the care of the pre-school child, and one that seems to hold promise of excellent results.

The so-called baby farm, from which unwanted babies so easily and inconspicuously slip away, is familiar to all readers of fiction. Conditions have undoubtedly improved, but vigilant and constant supervision is required to safeguard the child brought up by others than his own parents.

Of recent years the high mortality among babies in institutions, even the best, has forced a new attitude in this country toward the whole question of institutional *versus* home care for young children. Where boarding-out systems have been adopted by institutions, the children so boarded should be, and usually are, supervised by doctors and nurses employed by the institution itself, certain requirements being made of the foster mother in regard to routine medical inspection of the children under her care.

In addition, however, to the children for whose welfare public or private institutions are responsible, many babies are annually placed in boarding houses by their mothers or other relatives, and unless responsibility for the welfare of these children is assured by the state or city grave danger is to be feared. A large proportion of the babies so placed are illegitimate, and the young mother is ignorant of what constitutes proper care and even if she were better informed would be at a loss to secure it. Unloved babies die easily, and for this reason alone require a closer supervision than the child brought up in his own home. Public health nurses working preferably under state or city boards of health, have proved themselves well adapted to the work of inspection and supervision of baby boarding houses.

There are in this country many different laws and customs regarding the midwife, ranging from non-recognition or unrestricted licensing to registration, education and supervision. Broadly speaking, three methods of dealing with the midwife are advocated, first that she be ignored as non-existent, second that she be abolished and third that there be state or civic control of her activities. The first, though undesirable from every point of view, is not unnatural. The midwife problem

is most difficult of solution and in doubtful situations inactivity is always easier than activity. Where the existence of the midwife is ignored it is usually on the general principle that recognition implies sanction, but nothing is to be gained by such an attitude of mind. Either the midwife is a menace which must be fought as are other menaces to life and health or she is a necessary instrument, capable of performing better work under certain conditions than under others.

Whether desirable or not the immediate elimination of the midwife is unlikely, and the fact cannot be ignored that a large percentage of the obstetrical cases of the United States are at present under her care.

Any adequate supervision of midwives is dependent on two things: a prompt report of births, and a good record system duly checked by the proper authorities. Indeed one of the most valuable results of efficient supervision is the data that are slowly being accumulated. Midwife supervision by nurses, like the inspection of baby boarding houses, is usually best undertaken by state, county or municipal bodies, but where money is not forthcoming from public treasuries the value of the work may well be demonstrated by a private organization, though in these circumstances it is important to secure the closest cooperation of the local board of health, in order that the nurses may work under its authority and with its sanction. Systematic supervision is greatly simplified where the women are registered or licensed, but even when the midwife is officially unrecognized, supervision is quite possible wherever birth registration is compulsory. Unless, however, the midwives report births within the first forty-eight hours, much of the value of supervision is lost. Certificates when granted should be good only for one year, and renewal should be dependent on good work and strict obedience to law. Only normal cases should be attended, and the number of hours during which a patient is permitted to remain in labor should be limited. The midwife should be forbidden to operate, and should be required to report septic conditions of the mother, sore eyes of the baby, or any other abnormality immediately. Nor should she be allowed to be herself the judge of abnormal conditions.

Efficient supervision can only be accomplished by provision

for home visiting of the patients; for occasional visits to the home of the midwife, and the inspection of a bag that may or may not be the one used, are valueless. In towns and cities routine supervisory work consists in following up each case delivered by a midwife. In rural districts this will be impossible, but the general principle should hold, that only through actual inspection of the work of the midwife can the situation be controlled.

Perhaps the greatest secret of effective work with midwives is the ability on the nurse's part to gain their confidence. Stern measures are sometimes necessary, but it is the nurse who works with the midwife, not against her, who secures the best results. Occasional meetings of the midwives at some central place have been found helpful, even where no systematic education is considered desirable. These meetings if tactfully conducted make possible the explanation of laws and rules, the dissemination of some slight instruction, and the furtherance of a spirit of general helpfulness.

A strong child welfare nursing service is potent for far-reaching good, whether carried on by the unaided efforts of a single visiting nurse, working alone in a country district, who cares intelligently for children as part of her work, or by the united efforts of a large staff of nurses who have at their command the varied resources of a big city. The greatest value of such a service lies in the fact that its primary function is to help others to help themselves.

The parents are the natural guardians of their children's welfare, and those who can be so taught as to become practically independent of the nurse's help are the greatest successes, for above all, we must avoid killing or stunting the instinct of responsibility. If in our zeal we educate a city full of parents ready and glad to relegate this responsibility to others, we shall have paid too heavy a price for any number of fat and healthy babies.

Miss Julia Lathrop, former Chief of the Federal Children's Bureau, in speaking of the value of the nurses' work, tells an anecdote of a colored mother of a fine strong child. In reply to a remark that the district nurse had done a great deal for the baby, the woman said, "Oh Lor' no, Miss, the district nurse

didn't do nothin' for my baby. She just come and talked things over with me every week, and I was real glad to see her, but 'twas me, my own self, brung up this yer baby to be strong and healthy like he is. Nobody else could a done it."

This woman was right, nobody else could have done it.

The only real hope for the children lies in the education of fathers and mothers, and the strengthening, not weakening, of their natural feelings of parental responsibility.

Chapter 5

SCHOOL

Few Americans realize how slow their country has been to recognize a necessity for systematic care of the health of the school child. As a matter of fact the United States has been one of the last of the civilized nations seriously to consider the problem, though suitable provisions for health would seem to be a natural corollary of any system of compulsory education. France was the first country to make a beginning in the field of medical inspection, passing a royal ordinance in 1837 which charged the school authorities with the duty of supervising the health of school children, and attending to the sanitary condition of the school houses. These early beginnings in France, however, were not immediately followed by further development; and Brussels, meanwhile, by the appointment of regular school physicians in 1874, gained for herself the honor of being the first city to establish a system of school inspection in the modern sense of the term.

When in 1894 medical inspection was inaugurated in Boston, the United States merely followed the lead of France, Germany, England, Sweden, Russia, Austria-Hungary, the Argentine Republic, Chile, and Cairo (Egypt), which had all preceded her in such efforts.[1]

The school nurse, however, has not made for herself the place in foreign lands which has been accorded her in the English-speaking countries, a fact easily accounted for by the status of nursing in general, and of all public health nursing in particular. There can be little doubt that as the work of the nurse becomes better understood, there will be a greater demand all over the world for her services in the schools, for wherever she has made her entry her value has been recognized.

[1] "Medical Inspection of Schools," Gulick and Ayers.

Although other dates have been given, there seems little doubt that the first school nursing was started in 1892, in London.[2] An inquiry into the question of the feeding of school children was at that time being made, and a request for the assistance of a nurse came to Miss Amy Hughes, then Superintendent of Queen's Nurses in Bloomsbury Square. Miss Hughes determined to answer the call herself, and her weekly visits to the school in Wild Street, Drury Lane, revealed the fact that much unnecessary suffering existed among the children caused by uncared-for minor ailments, and that in consequence there was an unnecessary loss of school time. Miss Hughes' efforts were followed by the placing of Queen's nurses in a number of London schools, and in 1898 by the establishment of the London School Nurses' Society. This society, though doing such important work as a forerunner and example of what might be done, never itself undertook work on a large scale, as it was the policy of the association that school nursing was not legitimately the duty of a voluntary society, but should be financed from municipal funds.

The London School Board, though apparently not antagonistic, cannot be said to have been over-enthusiastic about the scheme if we are to judge from the following notice which appeared in 1900 in the London Gazette: "The School Management Committee give their consent to a nurse from the London School Nurses' Society attending each morning for an hour and a half to dress the eyes and sores of the children in those schools where the divisional members consider it desirable and make the necessary arrangements, provided that the Board shall not be liable for any of the cost thereof, and in any case where the school is visited by a nurse of the Society the Board provides a basin and kettle for the use of the nurse at a cost of three shillings for the two articles."[3]

In 1900 we find this cautious board experimentally appointing one nurse at a salary of seventy pounds a year to deal with

[2] "History of District Nursing in England and Other Countries," Amy Hughes, General Superintendent, Queen Victoria Jubilee Institute, Report of Jubilee Congress on District Nursing, 1909.

[3] "The School Nurse," Miss Honor Morten, Report of the Third International Congress of Nurses.

what seems to have been an epidemic of a virulent form of ringworm. Though this nurse was not permanent she must have added her quota to the evidence in favor of the work, for in 1904, urged thereto by the London School Nurses' Society, the London County Council took the matter into its own hands and appointed a staff of nurses under a superintendent, financing the work itself. Thus school nursing was finally established in London. In the meantime Liverpool, always advanced in such matters, had in 1893 started school nursing, the enterprise being paid for by voluntary contribution. Later other English towns and cities took it up, in some instances the nurse preceding the medical inspector and proving his need, in others following him as a necessary adjunct to his work.

It is interesting that in 1900 the secretary of the London School Nursing Society visited New York, and being much impressed with the municipal system of school medical inspection, carried back to England plans for improving the then rather inert and ineffective methods of the medical officers of the London School Board. Two years later Miss Wald of the Henry Street Settlement, New York, visited England, and was equally impressed with the possibilities of school nursing. In this way the pioneer work of each country brought inspiration to the other.

Previous to the day of medical inspection and school nursing the helpless teacher had no choice but to exclude all children who seemed physically unfit to associate with the others. The finding by the Henry Street Settlement workers of a boy of twelve who had never been to school on account of a tiny sore on his head, and who on investigation proved typical of numbers of other children, led to the agitation that finally secured school nursing for the school children of New York.

In the early days protection of the school child in school was the principal object of medical inspection, and as far as it went the new order of things was a vast improvement on past methods; for compulsory education in districts where the people were unfamiliar with the ordinary laws of health and cleanliness had made of the schools veritable hot beds of major and minor contagion. Isolation of the infected children until they were cured certainly seemed a wise and reasonable provision for the safety of the uninfected. Theoretically also the infected child

was cared for, inasmuch as he took home with him a card stating the diagnosis of his case, and advising that a doctor be consulted. It was, of course, hoped that the parents would secure for him the necessary treatment, and that in due time he would return to school wholly recovered from his difficulty. What actually happened was in many cases quite different. Though debarred from intellectual pursuits with his schoolmates, the mere possession of a card stating that he suffered from ringworm, scabies, or some other non-bed-confining disease, in no way interfered with his intimate association with them outside of the school precincts. Indeed he was not infrequently to be found sitting on the curb-stone waiting for school to be dismissed in order that he might not lose a moment of their society. Thus the one object to be gained by his exclusion from school, the physical safety of the other children, was defeated. As for the excluded child himself, it was only in comparatively few instances that the card so carefully filled out was potent for good. Occasionally parents, understanding from it that something was wrong, followed its suggestion and took the child to a doctor. In many instances, however, the child's incoherent account of the difficulty excited only the uncomprehending indignation of the parents. Why should not a mother object when told by her son that the doctor wanted him to have his eyes taken out and scraped?

The Henry Street Settlement realized that the natural result of school medical inspection without follow-up work was a great loss of school time to the very children who were least fitted to lose a day, because they were those for whom, as a rule, school opportunity ended with their fourteenth birthday. The Settlement, therefore, offered to place a nurse experimentally in the four schools in New York showing the greatest number of exclusions, with the object of proving the possibility of safely retaining the majority of the excluded children in school. The offer was accepted, and the point so well proved that school nurses were promptly appointed by the municipality. During the single month of September, 1902, 10,567 children were excluded from the New York schools, while in September, 1903, with the nurses in attendance, there were but 1,101 exclusions. These figures are readily accounted for when it is considered

that in many instances the causes of exclusion were pediculosis, ringworm, scabies and other troubles easily curable without loss of school time if vigorously treated, but of indefinite duration if allowed to go uncared for.

The first systems of medical inspection aimed merely at the detection of the more important contagious diseases, scarlet fever, diphtheria, whooping cough, chicken-pox, mumps, etc. A short experience showed the wisdom of considering likewise the parasitic diseases such as scabies, impetigo, and other diseases of the skin or scalp. At this point of development there was a halt, but it was not long before mere medical inspection began to be replaced by medical examination. Dr. Porter, State Commissioner of Health of New York, has defined medical inspection as "the search for communicable diseases," and medical examination as "the search for physical defects many of which furnish the soil for contagion." It goes without saying that if the whole physique of a child is considered with a view to obtaining a full knowledge of all physical defects in order that he may be restored to health, far more intensive work is required of doctor and nurse than when it is merely a question of the safety and well-being of the other children, to be brought about through the eradication of minor contagious diseases and the isolation of the more serious ones.

But school health work has not stopped here. The prevention of contagious disease and the correction of physical defects, though valuable and necessary, are not, after all, very constructive activities. If, in addition, children can, during their school-life, learn for themselves the principles and acquire the habits of health, a far more important end will have been served. With this realization dawned the era of health education, the systematic teaching of health to all children as part of the regular school curriculum.

In considering the history, therefore, of school health work in the United States, three distinct phases or periods of development may be noted, the later ones outgrowths of those preceding them. First, as we have seen, came the period when faith was pinned to a medical inspection that functioned for the sole purpose of dealing with contagion and preventing its spread; second, came the period when this responsibility was expanded

to include care for the general physical condition of the child; and third, came the period when to both of these responsibilities was added that of giving to the child, as an integral part of his school education, a workable knowledge of health both as it affects him individually and as it affects his community.

What, it may be asked, is the place of the school nurse in this march of progress? In the first two periods she played an important part in supplementing the work of the doctor, and through her function of home visiting bringing about results that would have been impossible without her. She need fear no curtailment of usefulness in the present period, for she is of even greater importance to a health program that depends for its success on the active cooperation of doctors, teachers, children, and parents. In it she still is an indispensable agent. To play the rôle assigned her, however, she will require a broad understanding of the entire scope of modern school health work and, though giving her time to her own peculiar duties, she must be able to see them in their relation to the whole scheme and feel an intelligent interest in all other phases of the subject.

The present position of the school nurse has been well described by Miss Bears. "The school nurse," she says, "will be in a stronger position if she can become that subtle influence in the school system recognized as essential for strengthening and supporting the work of the teacher, demonstrating the importance of proper lighting, careful seating, effective ventilation and good housekeeping, and performing as her major service the instruction in the homes where more psychology and less pedagogy are needed in order to break down the barriers of tradition, superstition and ignorance."[4]

Her duties will naturally depend upon the type of school and type of community that she serves. A nurse working in a school attended by children who come from good homes, who have intelligent parents, and who are under the charge of a group of progressive teachers, has naturally a very different problem from the nurse whose work lies among children whose home conditions are a constant menace to health, or the nurse working in a back-

[4] "The School Nurse's Niche," Elmira W. Bears, *Public Health Nurse*, September, 1923.

ward rural district where teachers, parents and children may all be at the A, B, C stage of health knowledge.

School nursing in the cities is perhaps more often specialized than any other form of public health nursing, but even in cities specialization is by no means universal, and in the smaller towns and rural districts where only one nurse is employed school work generally serves as an important point of departure for a health program that includes all ages. In the present chapter, however, we shall consider a school nurse's work as embracing only those activities that have to do with the school child himself, referring the interested reader to other chapters for a wider interpretation of her responsibilities, or for a more detailed consideration of the special types of service.[5]

The scope of school health work has been defined by the Advisory Committee on Health Education of the National Child Health Council as follows.[6]

1. Health training and instruction to be given to all children.
2. Physical training activities as related to health.
3. Health supervision of children and teachers including
   a. Health inspection.
   b. Health examination.
   c. Health correction.
4. Preparation of teachers for health training and instruction.
5. The hygienic arrangement and administration of the school program.
6. The hygiene of the school plant.
7. Mental hygiene.

In view of the rapid developments of the last few years it may be profitable to consider the work of a school nurse in its relation to such a program, though it will be understood that throughout large areas of our country far less advanced methods than these are in use.

In the first section, health training and instruction to be given

[5] Part III, Chapter 2, "County Nursing"; Part IV, Chapter 7, "The Nurse Working Alone"; Part V, Chapters 1 and 2, "Tuberculosis Nursing"; Chapters 3 and 4, "Child Welfare Nursing"; Chapter 6, "Mental Hygiene Nursing."

[6] "Health for School Children," Report of the Advisory Committee on Health Education of the National Child Health Council, School Health Studies No. 1, Department of the Interior, Bureau of Education, 1923.

to all children, is included such class room teaching as will train the children in health habits and give them an intelligent understanding of the principles of personal and community health. This teaching, it is felt, should be part of the regular school curriculum and should be continuous, from the kindergarten to the high school. In the past, classroom instruction in health subjects has frequently been expected of the school nurse. As, however, few nurses have had pedagogical training they are rarely successful as group teachers, and experience has proved that on the whole it is easier and less time consuming to teach a trained teacher what to teach than to teach a nurse how to teach. It is also desirable that health should be taught, not as an isolated subject, but in association with various other subjects, and many opportunities have been found to slip such teaching into the ordinary curriculum through, for instance, the making of health posters by the drawing class, or the writing of health essays by the English class. Moreover, in addition to these devices, a wise teacher may so teach the nature studies, history, geography, etc., as to "infuse" health throughout the child's entire school day, and this with very little direct reference to it. These methods of teaching are manifestly outside the province of the nurse, though this does not mean that a school nurse should never address the children in the classroom. She will undoubtedly often do so, but in considering the question of school health work it may be understood that the nurse supplements, not supplants, the teacher, and that she will work through, not for, her. In other words, that it is the teacher, not the nurse, who is responsible for all regular class room health teaching.

Modern health education is based on the fundamental idea that within reasonable limitations health is attainable by everyone who wishes to possess it, provided they know how to secure it and are willing to set about getting it in the right way. The essence of health teaching has been said to lie in the practice of health habits until they become automatic, but perhaps even more important than the acquisition of habits is the awakening of a desire for physical perfection. Though a certain amount of such education may be given to adults it is in childhood that these principles, habits, and desires can best be acquired, and unless a child himself learns the lesson all objective treatment is

of limited value. A few years of experiment have demonstrated a number of interesting points:—that if suitable methods are employed for the different age groups, children can be very readily interested in health; that little children best understand it through health plays, health songs, health rhymes, etc.; that older children enjoy the health leagues and health crusades, which appeal to the instinct of group action and group competition; that still older children become interested in the various phases of community health, and show themselves surprisingly ready to forego the gratification of personal desires for the sake of a common good; that young people in the senior grades get most from their health work if it is related to their scientific studies, biology, physiology, etc., and to their courses in political economy or domestic science. They also become greatly interested in the health problems of their own communities.

The love of self-government and competition common to all children has been peculiarly helpful in developing school health work, and through the health leagues and health crusades the children themselves have learned to take an active part in health programs. If carefully controlled and directed into channels of kindliness and helpfulness there is no more powerful instrument for good than this love of management, and the children's interest in each other's progress has in many instances brought about results otherwise impossible. Practice of "the rules of the game"[7] or the "health chores"[8] form a fair criterion of a child's interest, and through them he acquires habits useful to him throughout life. It goes without saying that unless teachers and nurses themselves observe the rules of the game, or their adult equivalent, the children will be quick to detect a lack of sincerity in the teaching.

[7] The rules of the game:

A full bath more than once a week.
Brushing the teeth at least once a day.
Sleeping long hours with the windows open.
Drinking as much milk as possible but no tea or coffee.
Eating some vegetables every day.
Drinking at least four glasses of water every day.
Playing part of every day out of doors.
A bowel movement every day.

[8] See Part V, Chapter 2, page 269.

A nurse's part in this program will depend, as we have said, upon the conditions under which she works. Where there is a corps of competent teachers (competent, that is, to teach health) she need only stand ready to give such demonstrations as may be required of her, or to assist by help or advice when appealed to. Her main responsibility in the health education program will then lie in such home instruction of the parents as will give them an intelligent interest in the health progress of their children, and a desire to back the school in its efforts. In backward communities she will naturally be expected to take a more active part in helping the teacher to introduce health education into the school.

As a first step in dealing with the health of individual children the importance has been recognized of a routine system of weighing and measuring each child. Such a system has many advantages, furnishing as it does an effective means of securing the cooperation of the parents and a basis for demonstrating the need of health work. It also serves as an excellent introduction to health education, and enables the school to judge somewhat at least of the success of its efforts. It is usual to weigh each child monthly, and to measure his height two or three times a year (in September, January, and June). Every child who falls below ten per cent.[9] of the weight estimated as normal for his height and age is considered outside the "zone of safety" and in consequence in need of special attention. Children fifteen per cent. above the average height or weight are also considered abnormal. The number of these is always so small in the lower grades as practically to present no problem, but in the upper grades and high school the overweight child is frequently found.

For some years it was felt that height and weight furnished an executive guide to the nutritive condition of the child, some authorities even going so far as to believe that children within seven per cent. of the average could be safely dismissed as presenting no evidences of malnutrition. The result of further study tends to show that this is not the case, and that a considerable number of children formerly considered within the safety zone prove on thorough physical examination to be suffering from malnutrition. Nevertheless, though undoubtedly too much has

[9] Seven per cent. is frequently substituted for ten per cent.

been claimed for the weight and measurement system as an infallible index to nutritive conditions, it is of great value and plays an indispensable part in all school health programs.

The psychological effect on the children of weighing day is important. Each child should be made to feel a personal interest and pride, not only in his own gain, but in that of his room collectively. For this reason something of a function may be made of the performance. Weight charts should be hung up in the school room and so arranged that the children can understand them and be able to follow results. In her talks a nurse will find the weight chart an excellent theme on which to enlarge. Weight records should be sent home to the parents as a matter of routine, and may be advantageously prepared by the children themselves. On his return to school after an illness a child should be weighed and his weight properly recorded.

The duty of weighing and measuring the children has been variously assigned to the teacher, to the nurse, and to the children themselves. Too great loss of time has been found to attend the last method unless worked out in such a way that the older children weigh the younger ones. For the nurse this duty is usually prohibitive because of the number of children under her care. It is the teacher, therefore, who usually performs it, or who directs the older children to whom it is delegated.

Section two of the school program deals with physical training activities as related to health. This section includes supervised play, school athletics, gymnastics, etc., and with these a nurse, as a rule, has little to do. Such activities serve of course other purposes than that of increasing physical health, but play and exercise are so important a part of any health program that a school nurse's interest should include them, and when working in small communities any efforts she may be able to make toward their furtherance will certainly advance the cause of health. If corrective gymnastic work is undertaken, careful individualization of each child is necessary.

Section three, supervision of the health of children and teachers, may be considered under three sub-headings: "(a) daily health inspection, to detect communicable and other acute diseases as well as other conditions adverse to health; (b) health examination, to chart the condition of the child, reveal his phy-

sical or mental defects, and indicate the relation of such defects, if any, to his capacities; (c) health correction, to include all steps necessary to secure remedial treatment of defects, including the correction of malnutrition, in cooperation with parents and family physician."

Health inspection to detect communicable disease was formerly considered one of the principal duties of the school nurse, and time for its performance was unsparingly taken. It is now felt that if the routine daily inspection of the children is carried on by the teacher, quite as satisfactory results will on the whole be attained and the time of the nurse can be saved for more intensive work with those especially needing her attention. Through the selective process sometimes known as "screening," all cases requiring it are brought to the further attention of the doctor or nurse. For this work teachers will require training in what to observe, a training now attainable in many normal schools. As a large number of teachers are, however, at present without such special training, a nurse must expect in many instances to do very definite work in organizing a satisfactory system of daily inspection, and must stand constantly ready to assist in its accomplishment.

The following list of symptoms to be noted is contained in a pamphlet, issued by the Massachusetts Board of Education, entitled Some General Symptoms which Teachers should Notice and on Account of which Children should be Referred to the School Physician.

Emaciation.
Pallor.
Puffiness of the face.
Swellings in the neck.
Shortness of breath.
General lassitude and other evidences of sickness.
Flushing of the face.
Eruptions of any sort.
Cold in the head with running eyes.
Irritating discharge from the nose.
Evidences of sore throat.
Coughs.
Vomiting.
Frequent requests to go out.

Under different systems a school nurse carries a varying degree of responsibility in regard to contagious diseases, but everywhere she is expected to do her part in the detection of early symptoms and the prompt notification of the doctor in regard to them. In times of epidemic it is advisable wherever possible to

aid the teacher in daily inspection, for the suddenness of the onset of some of the contagious diseases makes early diagnosis of the utmost importance. In carrying this responsibility a nurse should thoroughly acquaint herself with the earliest symptoms of all of the contagious diseases of childhood, and keep constantly on the alert to detect them. Though she must avoid becoming an alarmist, it is wiser to err on the side of too much reporting rather than too little, for the stakes are high, and a little carelessness may lead to serious consequences. Much may be accomplished by instruction of mothers in regard to the symptoms which should decide them to keep their children at home. Exclusion for contagious diseases and readmission after recovery should be in accordance with the state laws, and also according to the most approved modern methods.

Health examination, if adequate, presupposes the services of a school physician under whom the nurse will work. For years complete annual examination of every child has been the goal toward which school medical departments have been working, but after a number of years of effort some of the more thoughtful are questioning the practicability of this policy. In most communities the budget does not permit the employment of doctors in sufficient numbers for a truly adequate annual examination of every school child, and the tendency has been toward hurried, and consequently superficial, work. Unless ample financial support is available is it not better to restrict the number of routine examinations, and to make each more careful and complete? A thorough examination given the child on his entrance to school (the kindergarten if he attends it), a second one either a year later or in the fourth or fifth grade, and a third in the eighth grade, about the time of adolescence, are perhaps better than the more frequent and less thorough examinations now so common. Routine examinations differ somewhat in different localities, but should include at least the following points: hearing and vision tests; relation of weight to height and age; examination of teeth, nose, throat, skin, heart, lungs, spine, posture, feet; nervous condition; mental and emotional state; glandular conditions and general tone.[10] More complete examinations may be made when

[10] "Health for School Children," School Health Studies No. 1.

indicated or perhaps on the request of the parents. Mental tests may be given and results recorded at the same time. The health record of each child should be filed with his academic record and should be available for reference throughout his entire school life.

Re-examination of children showing defects is valuable in checking results and in determining the amount of corrective work actually accomplished. Where examinations are made before the issuance of work papers, re-examination to discover the physical effect of the work is desirable.

Unfortunately there is a prejudice in some communities against removing the clothing of the children for examination of the heart and lungs. As the interest of parents is more fully aroused, and as they can be more frequently induced to be present at the examination of their children, it is hoped that public opinion in this matter may be changed in favor of greater accuracy of diagnosis.

Routine examination should not be confined to the children alone. It is quite as important that the teachers should also benefit from a periodic examination that will insure an intelligent understanding of their own physical condition.

If adequate routine examination of school children presupposes the services of a school doctor, what is to be done in those schools, of which there are many thousands in the country, where no school doctor is employed? Occasionally volunteers may be enlisted from the local medical association, but this is rare. Failing a medical examiner a nurse must do the best she can, and while naturally making no diagnosis, must endeavor to select those children that in her opinion are suffering from abnormal conditions of the eyes, ears, nose, throat, skin, teeth, breathing and general mentality, urging the parents to secure for them competent medical or dental advice.

Every school nurse should be alive to the problem of tuberculosis and should bring to examination all children whom she knows to have been exposed, and all who manifest suspicious symptoms. As the importance of childhood infection is increasingly recognized, the school nurse is expected to play a more and more important part in the anti-tuberculosis campaign, and to

do this she must be prepared to keep up with the modern trend of thought and the current literature on the subject.[11]

Where fresh air rooms or fresh air schools exist, the nurse's relation to them will be peculiarly close, for there is far more to the conduct of a fresh air room or school than the mere admittance of fresh air. As they function for the purpose of building up the children who have been found below par, special emphasis is naturally placed upon the question of health. The children are weighed and their temperatures are taken at frequent intervals (usually once a week), hot lunches are provided with milk between meals,[12] and an hour's rest period arranged for. Time is given not only to health teaching but to health "living," and special meetings are held for the mothers with intensive follow-up work in the homes. As all this involves heavy expense, only a carefully selected group of children is usually admitted, those as a rule who not only require such special treatment but those whose parents are willing to cooperate with the school to the extent of planning the home life of the child on as healthful a basis as possible, and who will attend to the remedy of such physical defects as may be pointed out to them. It has been found that one fresh air room to every thousand children will take care of the most urgent cases.

Health correction is a natural sequence to health inspection and health examination, and includes, according to the program which we have been following, all steps necessary to secure the remedial treatment of children with defects, and also the correction of malnutrition. In this field lies one of the most important functions of the school nurse, and in it is included her work in the homes. Hitherto the school has been obliged to carry an unwarrantable burden in the correction of defects because so little has been done in this respect before the school age. With an awakening public conscience in regard to care for the pre-school child the present situation cannot fail to be improved. The most common defects are those of the teeth, nutrition, eyes, ears, lungs, heart, and nervous system. Of these the two first named take precedence numerically.

[11] See Part V, Chapters 1 and 2.

[12] The provision of between-meal food for children who can command three suitable meals daily is a matter of controversy.

Within the last decade and a half, mouth hygiene has acquired new significance, through the discovery that much general ill health is caused by a poor condition of the teeth. In the old days a dentist was consulted principally with a view to saving the teeth themselves, and those who could not afford dentists' bills merely kept each tooth as long as possible, and when toothache became unbearable had it extracted. When the number so parted with made mastication wholly impossible the remaining few were pulled out, and a false set purchased. Modern scientific study has shown that not only are serious digestive troubles caused by such a method of treatment, but that carious teeth form centers of infection for disease, and that a seriously lowered vitality may be directly traced to a general infection resulting from the absorption of pus from a diseased tooth.

In mouth hygiene there are three essential principles: teaching the use of the tooth brush; care of the mouth by a dentist; and, perhaps most important of all, instruction in regard to diet. Tooth brush drills are often a part of the health education program, and many schools have arranged for the services of a school dentist, while the question of diet is increasingly considered. Where this is not the case a nurse must do her best to arouse the interest of both children and parents in the subject, and to procure for the children proper dental attention.

Malnutrition has long been suspected of playing a leading part in the physical and mental condition of school children, but it is only within recent years that the magnitude of that part has been recognized. To malnutrition are now assigned many of the difficulties under which children labor and which were formerly treated without reference to it. Bad posture, among other things, is considered principally due to malnutrition. To combat the evil, nutrition clinics were first started which, under the better name of nutrition classes, quickly became a part of all progressive health work. These special classes have been carried on within the school itself as part of its health program, and have also been maintained by dispensaries and other outside agencies. Special sessions for nutrition work are also sometimes held during the summer months. The special class method of nutrition teaching is now challenged by those who feel that there should be no limitation of these advantages, and that every child should profit

by them. As all successful nutrition work with children implies the active cooperation of the child's parents, a nurse's part in gaining this cooperation is most important. Where the services of a trained nutritionist are available the nurse will naturally work with her in securing her ends. Home cooperation can often be obtained by interesting the girls in the domestic science courses in the subject, and teaching them how to feed undernourished brothers and sisters.

In the correction of such defects as those of the eyes, nose and throat a nurse's responsibility takes the form of working in cooperation with the teacher to bring to the attention of the school physician all suspected cases, and, after diagnosis, in explaining to the parents the notices sent them, and persuading them to take the child to the family doctor or a free clinic for treatment. If there is no school doctor the nurse herself must, as we have said, be the judge of the necessity for medical attention.

A nurse working in schools situated in the poorer districts will be obliged to spend a considerable proportion of her time on diseases of the skin caused by uncleanness, such as scabies, ringworm, impetigo and pediculosis. To the beginner these troubles may seem insignificant in that they do not threaten life, but there is, perhaps, no better test of a school nurse's efficiency than is shown by her success in dealing with these difficulties, for in so doing her instructive ability is tested to the full. For years pediculosis defied the most vigorous efforts, principally because any treatment of the school child must be extended to other members of the family if it is to be of the slightest use. In this, as in all other effort that involves the cooperation of the child or his parents, the nurse's power to deal with people will be called into play, and unless she possesses this power, and is also able to raise the ideal of her work far above its sordid details, she will never be either a very happy, or a very successful, school nurse.

Much of the school nurse's time has always been wasted in repeated visits to households where she has struggled in vain to induce the parents to secure proper treatment, to buy glasses, or to follow some desired line of action. Again and again has she been baffled, not by opposition, but by the utter indifference of the whole family. The situation when analyzed is often a very simple one, the child himself does not want to have his head

treated, is unwilling to go to the doctor or dentist, or does not like to wear glasses. Our forefathers would doubtless have been shocked at the independence of the modern child, particularly the forefather of foreign birth. Be this as it may, the fact remains that John and Mamie, Ikey and Rachel, Tony and Marietta, together with numberless other small American citizens whatever their antecedents, do very much as they please about a great many things. It therefore behooves the school nurse to secure the intelligent cooperation, not only of the children's parents, but of the children themselves. This, of course, she has been trying to do for years, but there is no stimulus like the public opinion of our peers, those who think as we think and whose actions are inspired by the same motives as our own. In all such effort the nurse of the present day is greatly aided by the new trend of health education and by the health chart. The psychology of the health chart on which the defects of each child in the room is charted and displayed has been questioned because of its emphasis of the pathological. The common experience of teachers and nurses, however, is that the effect on the children is good when used as a basis for remedial effort and a means to stimulate a desire for physical perfection, and that their interest in securing a high health standard for their room reacts healthily and vigorously in directing individual attention to the remedy of defects.

In her home visiting a school nurse will need to conform to the rules laid down for her. It is an almost universal rule that school physicians do not make suggestion as to the treatment of sick children, and the nurse naturally conforms to like restrictions. School work indeed differs from other forms of public health nursing in that though diagnosis is obtained, treatment is not ordered. To the nurse used to different methods this situation sometimes presents difficulties, for it is hard to see usual lines of treatment ignored after a diagnosis has been made by the school doctor. She must be content, nevertheless, to play the part assigned her, even though assailed by the temptation to overstep the mark for the sake of some individual child.

A school nurse, dealing as she does with parents through her interest in their children, has it in her power either to strengthen or weaken the bond between the foreign mother and her Ameri-

canized child. Few native born Americans realize the difficulties of these foreign women who come to the new country too old in years, and too firmly moulded by tradition, to accept new standards or adopt different customs. It is, alas, unfortunately easy, in our efforts to give to the child an education that will fit him to his new environment, to take from him that most precious of possessions, a mother's influence. In the mere matter of health, his home and school teachings are often at complete variance. If the child is quick and intelligent he easily assimilates the new doctrines, often gaining at the same time a most undesirable impression of his mother's ignorance. In his dealings with her he has a great advantage, in that he and his brothers and sisters, together usually with his father, speak a language which she cannot understand. Indeed this occasionally goes farther, and the child so far forgets the tongue of his forefathers, or fails to acquire it, as to make speech with his mother actually difficult. In this situation lies real tragedy, no less for the child unconscious of the value of his lost respect and reverence, than for the pathetic and bewildered mother. The school nurse in her home visiting among foreign parents will do well to remember this tendency, and do her uttermost to foster parental dignity.

Let no one feel, in considering the question of school health work, that it is only in the large cities that doctors and nurses are required. As we have seen in a previous chapter, investigations have shown that conditions in the rural districts are often lamentable, and offer as many examples of defective children as do the city schools. Indeed it has been found that statistics dealing with country school children, apparently living under the most desirable conditions, compare in reality unfavorably with statistics of city children living in the congested districts of large cities, but with the advantage of good medical inspection and supervision. From the point of view of the city child this should be encouraging. From the point of view of the country child it should be a warning to be heeded.

With the activities described in sections four, five and six of the program a nurse has less to do though she should not be uninformed regarding them. The subject of section four, the preparation of teachers for health training and instruction, is indeed one in which every nurse should feel a sympathetic interest.

Furthermore, the number of teachers who have had the advantage of such training in their normal schools is as yet relatively small, and many women are teaching who know very little about health. To these a nurse may be of help by sharing with them her own knowledge on health subjects. Section five deals with the hygienic management of the school program, and, though theoretically carrying no responsibility for this, a nurse will find that a little reading on this subject will open her eyes to many interesting facts and enable her to be far more intelligent in aiding the teachers in their work; such facts, for instance, as that a school should provide a suitable balance between work, rest and play; that the children should not be overtaxed by undue study; that they should be graded according to their mental and physical development and not according to their age; that those who are retarded or defective should be taught separately; that the curriculum should provide for a proper daily sequence of studies; that text books should be clearly printed; etc., etc., etc. Of section six, hygiene of the school plant, much the same may be said. Here again a school nurse, though not directly responsible, should be able to recognize the advantages of a correct construction of the school buildings and equipment, the necessity for adequate and suitable toilet facilities and the importance of proper arrangements for lighting, heating, cleaning and ventilating. The county and rural nurse can often be of great service in helping toward a better adjustment of these things.

With the last section of the program, mental hygiene, the school nurse is on her own ground again. There is probably no field of public health nursing offering today such an opportunity for development as that of mental hygiene, and in that field, work with children unquestionably promises the richest rewards. We no longer expect to struggle only with the advanced case of mental disease. Our best efforts may now be expended on preventive work with the nearly normal, and it is to the school that students of mental hygiene are looking for a mental hygiene program that will prevent the havoc of later years. For consideration of this subject, however, we must refer the reader to the following chapter. Discussion of it here would involve unnecessary repetition.

The proper place for the school nurse in the administrative machinery of the state, county or municipality has been the

subject of much controversy and the pendulum of public opinion has swung many times backward and forward regarding it. Whether the nurse shall function under the department of health or the department of education, is an old and familiar question. There are many arguments in favor of each method. If placed under the department of education the nurse automatically becomes an integral part of the school system, and her work is perhaps for this reason more easily correlated with that of other workers in the same department. There is also an advantage in an assumption of responsibility by the department of education for the entire education and well-being of the child, as health teaching both in school and in the homes thus becomes a part of a general educational scheme. On the other hand one of the principal responsibilities of the school nurse is that of preventing the spread of contagious disease, a responsibility that is inexorably connected with a department of health. Also, and this is an important point, all schools are not a part of the public school system, and in consequence do not come under a department of education. The parochial schools and the private schools are wholly outside its jurisdiction and may be best served by a health department. There is one other point in favor of board of health control, namely: the fact that, as school nurses form as a rule but a part of the group of municipal or county nurses, it is somewhat easier for a nursing bureau to function when all come under a single department. This point, however, is not of great importance, for it is quite possible for a nursing bureau functioning under a board of health to detail nurses to any other department requiring their services. Local conditions cannot fail to affect the problem, but at present the swing of the pendulum seems rather toward assumption of responsibility by the department of health, though it must be admitted that there is no general consensus of opinion except on one point that cannot be too strongly emphasized, namely, that no successful work is possible without concerted action from both departments.

School nurses usually work under the direction of the medical director or health director of the department, but if the staff consists of more than two or three nurses a superintendent who is herself a nurse should be appointed to act under his direction, having the responsibility of selecting, training and supervising

all members of the nursing staff. At the risk of repetition it must again be reiterated that all systems of nursing work show that only through the intelligent administration of a nurse executive, vested with full authority within her province, can efficiency and evenness of work be maintained by any nursing staff, and school nursing is no exception to this general rule. That nursing cannot be well taught or supervised by anyone but a nurse, is one of the earliest teachings of Florence Nightingale, and one which over half a century of nursing experience in all its various phases fully justifies.

The amount of work that should be assigned to each nurse will depend somewhat on the type of children cared for, the distance of the schools from each other, as well as the demand made upon her time for home visiting. Experience in many cities tends to show that the ideal ratio is one nurse for every two thousand pupils in congested districts, but this is rarely attained and many nurses in city schools average almost double this number. In small cities of twenty or thirty thousand inhabitants with a school enrollment of from three to five thousand, three nurses are required to do good work. In very poor neighborhoods, where bad housing and insufficient food produce their inevitable results, one nurse is kept very busy with two thousand or even fifteen hundred children.

Nurses should serve for the calendar, not the academic, year, for city school children usually lose ground during the summer vacation and a nurse's oversight is peculiarly needed at that time.

In review it may be said that the duties of a school nurse are:

1. To acquire such an understanding of the development of modern health education as will make clear her own relation to it.

2. To assist the teacher by advice and counsel in the furtherance of the work of health education.

3. To assist the teacher to inaugurate and carry out a satisfactory system of routine health inspection.

4. To assist the school doctor in his periodic examination of the children, and to care for such minor dressings as may be referred to her. In case no doctor is available, to make such examinations as will enable her to bring to a physician's attention those cases requiring his services.

5. To induce parents, through her most important function of home visitor, to secure for their children as healthful conditions as individual

situations will permit, and to persuade them to have the defects discovered remedied. In addition, to make clear to them the fundamental principles underlying modern health education, to the end that they may intelligently play their part in the health progress of their children.

In all these tasks a nurse has many allies, with all of whom she will naturally cooperate to the uttermost. To be successful, the health work of a school must be understood by the community that it serves, and for this understanding her services as an interpreter are required.

The school nurse is not a passing experiment. She is a vital part of one of the most important of our national institutions. Through her work American children are physically fitted to receive the education that is, in its turn, to fit them for the responsibilities of citizenship. It is her duty to awaken parental responsibility in new directions and so to emphasize the value of health, both to children and parents, that they will realize that its attainment is worth some real sacrifice on their part. By so doing she is helping to make the American school an institution where body as well as brain is developed for a life of usefulness.

Chapter 6

MENTAL HYGIENE

The history of the care of the mentally ill is too well known to require harrowing repetition. We have travelled far since the days of cruelty and neglect, but even yet in some states patients suffering from mental diseases are to be found in alms-houses and poor-houses, while the laws governing commitment to institutions in many places still have more in common with legal proceedings against a criminal, than the admission of a suffering patient to a hospital for the sick.

It is interesting to trace the attitude of the public mind toward mental disease in the immediate past. Not so very long ago the principal idea was to get rid of those who could not be fitted into a normal environment. Though friends and relations must always have suffered acutely, the community as a whole accepted the situation calmly enough. Later came the hope of cure by means of scientific diagnosis and treatment. Hospital care replaced alms-house care and that of the hardly less cruel asylum, and the community rejoiced at the return to health and usefulness of many who under an earlier régime would have passed their lives in exile.

At this point there has been a long pause. Diseases of the brain are still regarded by the general public not quite as are other diseases, and the mental hospital is only beginning to acquire the same status in the public mind that has been accorded hospitals for other types of cases. Also, and this is most important, the patient suffering from a mental disorder is frequently allowed to go uncared for until his disease is far advanced.

We have long ago learned that with physical disabilities early diagnosis and treatment are of the utmost importance if satisfactory results are to be obtained. We no longer wait until a baby becomes sick to visit him, but try, on the contrary, to deal with his health even before he is born. We do not wait until the

tuberculosis patient takes to his bed, but go out to search for him in the highways and byways in order to bring him under care while there is still hope for improvement. Illustrations of this effort to do preventive rather than alleviative work might be multiplied indefinitely, but it is too familiar to public health nurses to require more than passing mention. The same nurse, however, who is zealous in her preventive campaign and whose trained eye is quick to see symptoms of either physical or social maladjustment, will often totally fail to detect early manifestations of abnormal mental conditions. This is not due to carelessness, but rather to the fact that until comparatively recently everyone has been content to wait until patients of this type showed such marked symptoms of disease as to be unmanageable at home. Disorders of the brain and nervous system are not different from disorders of other parts of the human body, and the theory of the "stitch in time" that "saves nine" is no less applicable. Therefore, nothing is more wasteful than a waiting policy.

Public health nurses have been somewhat slow to grasp the opportunities offered in the field of mental hygiene. The average nurse has done her best to bring under medical supervision the cases that she has run across in her daily work, but as a rule she has seen only the most obvious need. This is not surprising, because hitherto graduates of general hospitals have known little or nothing of the difficult technique of mental nursing, and because of this ignorance have been inclined to minimize its importance. The present tendency toward a freer affiliation between general and special hospitals, by means of which many more nurses receive special training, is undoubtedly changing this situation; but at the present moment it is the social worker rather than the public health nurse that is making the most important contribution to the field of mental hygiene. Very possibly this is as it should be, and the peculiar training and experience of the social worker may always make her the best instrument for the work. It would seem, however, that the same qualities and background that have rendered the public health nurse so successful in other similar fields, notably those of tuberculosis and infant welfare, can hardly fail to serve the same end in the field of mental hygiene. There is also among psychiatrists a growing emphasis on the definite physical origin of much of the

mental and nervous disease formerly attributed to psychiatric causes alone. Here a nurse trained to the observation of physical symptoms undoubtedly finds a place unfilled by the social worker.[1] In the present chapter no plea is made for the nurse as opposed to the social worker, but as a number of public health nurses are already in the field and as in many localities where nurses are at work there is no social worker, a discussion of the subject of mental hygiene as applied to public health nurses seems pertinent.

Insanity is not a single disease from which the disordered mind suffers, but is a generic term that applies to a number of diseases of the brain.[2] These diseases spring from different causes, show different symptoms, run different courses and terminate in different ways, and each, therefore, requires a different treatment. In some cases the first manifestations of trouble indicate the actual beginning of the mental breakdown. In others danger signals are shown which to the ordinary observer pass as mere peculiarities of temperament, but which to the trained eye are found full of significance. Unfortunately at the present time these early danger signals too often come to the notice of a psychiatrist only as part of the history of a patient already ill enough to be admitted to a hospital for mental diseases. As much of the treatment of mental and nervous troubles consists in its essence in the application of two principles, training and rest, the value of early diagnosis will readily be seen. Even though many individuals showing well-developed symptoms of maladjustment and personal mismanagement do not eventually become insane, early

[1] Dr. Arthur H. Ruggles, of Butler Hospital, Providence, says, "The psychiatrist who, in any essential, neglects the thorough physical examination of his patients is the one who will make the most mistakes, and I think the same holds true of the mental hygiene nurse. She must know the psychological end, but the approach should also be through an estimate of the physical condition. I believe it is in this field, preeminently, that there is a definite place for the mental hygiene nurse that the psychiatric worker could never fill." Personal letter to the Author, October 15, 1923.

[2] Dr. Myerson says, "As a matter of fact there is no such concrete entity as insanity. The term is abstract and has no real meaning whatever, and the sooner it is dropped from literature the better for humanity. In other words, mental derangement is only a symptom having many possible causes." "Heredity and Mental Diseases," Dr. Abraham Myerson, *Mental Hygiene News*, January, 1923.

diagnosis is none the less desirable, for much may be done by proper treatment to save them and their families from unnecessary suffering and discomfort. For those who stand at the cross-roads, unconscious that in one direction lies a normal life and in the other mental breakdown, it is pathetic that in so many instances there is no helping hand to point out the safe way, or to assist the helpless traveller to take it.

Mental hygiene work presents many phases, and may be done in many different ways. Nurses, like social workers, may be employed by a hospital and do their work in connection with its out-patient department in following up its discharged patients, or they may be on the staff of a public health nursing organization. They may specialize in mental hygiene, or they may be generalists, taking their mental or nervous cases in the day's routine. They may work individually with the patients, or they may act as consultants and advisers to other nurses responsible under the generalized system for the patient. If a nurse works from a hospital her duties and field of endeavor will be more or less clearly defined. If she is part of the staff of a public health nursing organization she must be prepared to find that the term "mental hygiene" covers a broad field, and that her list of patients will include the helpless idiot or imbecile, the higher grades of the feeble-minded, the epileptic and the chronically insane, those suffering from recurrent mental disturbance, the alcoholic, the would-be suicide, the sufferer from general paresis, the so-called nervous, the child presenting a behavior problem, and those who may be otherwise normal but present such marked peculiarities of temperament as to make family and social adjustment difficult.

It is interesting to note that in mental hygiene, as in every other form of constructive health work, an increasing emphasis is being placed on the child. The feeble-minded child has long been a recognized problem, but as we realize that mental trouble is the result not merely of structural derangement of the brain or nervous system but of a culmination of continued habits of faulty adjustment to the ordinary situations of life, it becomes apparent that an important field of work lies in the prevention of such habits.

The question of the removal from home of a feeble-minded

child must be an individual one dependent on home conditions, and the ability of the mother to give proper care and instruction without undue prejudice to the other members of her family. Experience is proving that numbers of children who would once have been considered quite helpless are capable of profiting by instruction to the extent of learning to care for themselves, and even, under favorable circumstances, of later earning a certain amount toward their own support. Such instruction is usually best given in an institution, though not necessarily so. Many mothers very naturally long to keep their defective children with them, but it is on the whole unwise to encourage this if by so doing a mother is so overburdened by care that the other children of the household are deprived of a normal home. This also may be said of the epileptic child.

A better understanding of epilepsy is proving that many of the cases formerly so diagnosed are now known to have as their basis old birth injuries, syphilis, brain tumors, etc. Persistent convulsions, therefore, require a minute scrutiny before their cause by be assigned, and in arriving at conclusions the data obtained by the nurse may be of the greatest value. Epilepsy, when found, always presents a problem, for the care of an epileptic in the average home is difficult.[3] A large number of cases have an inheritance of feeble-mindedness, epilepsy, migraine, alcoholism or insanity, and where the epileptic symptoms are at all marked there are likely to be other deviations from the normal.[4] Here again early diagnosis is important. If a tendency to the disease is known, much may be done by wholesome living, diet and self-restraint to guard against attacks during the critical period of childhood. Recovery grows increasingly difficult with each succeeding attack.

Undoubtedly one of the most effective ways of dealing with the mental health of children will eventually prove to be through

[3] Epilepsy seems to have been more easily diagnosed and treated in colonial days. Roger Williams wrote to Governor Winthrop in a letter dated 1660, "My youngest son Joseph was troubled with a spice of epilepsy. We used some remedies but it hath pleased God, by his taking tobacco, perfectly, as we hope, to cure him." "Providence in Colonial Days," Gertrude Selwyn Kimball.

[4] "Epilepsy," Everett Flood, M.D., *Boston Medical and Surgical Journal*, September, 1916.

the school system. Much has already been accomplished by means of special schools and classes for atypical children, but much still remains to be done. These are by no means as yet universal, and even where they exist considerable opposition to them remains to be overcome. In the great majority of schools, too, there is still lacking a sufficiently close relationship with the parents of the children. There are also, particularly in rural districts, a large number of defective children who are not in school, either because no provision is made for them or because of the unwillingness of the parents to send them. Dr. Bailey says, "Of the million children in that river of promise flowing through the schools of the State of New York, forty-five thousand are deflected from the main current because of defective intelligence.[5]

Dr. Bailey adds to this statement a description of the wrong way and the right way to deal with those thus deflected, showing that unless school discharge is followed by medical supervision, special classes, home follow-up work, and, where necessary, proper institutional care, there will inevitably result a court record, idleness, hoboism, prostitution or illiteracy. Surrounded by the right influences, on the other hand, he believes that such defectives have a fair chance of employment either in wage-earning institutions, or, under suitable arrangements and proper supervision, in the community at large.

Though the problem of the intellectually defective child is now fairly well recognized, that of the potentially psychopathic child has received less attention, though it offers, as Dr. Haviland points out, far more tangible results if properly attacked. He says: "While the defective can only be trained for social usefulness within the limits of his restricted capacity, the psychopathic child can be guided into a full normal life of highest social value, instead of blundering along as an unhappy, inefficient individual who is peculiarly liable to mental disease."[6]

We are only at the very beginning of this work, but its possibilities must be apparent to every public health nurse who has

[5] "State Care, Training and Education of Mental Defectives," Pearce Bailey, M.D., *Mental Hygiene,* January, 1922.

[6] "A State Mental Health Program," C. Floyd Haviland, M.D., *The State Hospital Quarterly,* August, 1922.

vainly tried to give helpful advice about the upbringing of the difficult child, the nervous child, the cruel child, the temperamental child, the abnormally shy child, the child consumed by jealousy, the child unhealthily interested in sex matters, or the many other types of children who fail to fit their environment and are so evidently headed toward disaster. Were scientific treatment possible, based on a true understanding of the real difficulty, what a load would be lifted from the shoulders of every conscientious nurse.

Some of the most important work with children is that in connection with the juvenile court, where a mental examination of every child is desirable. We should not wait, however, till the path of misbehavior has already been entered upon, but should begin our preventive program at an early moment. Indeed, observation and training cannot begin too early. A whole field of study, as yet but little cultivated, undoubtedly lies in the anomalous behavior of infants,[7] but such studies will probably be most effectively pursued in institutions where large numbers of babies can be observed under uniform conditions. For the older children of neurotic tendencies or peculiar habits, special clinics are beginning to be started.

Such a clinic is the habit clinic in Boston, opened in 1921 to meet the need of help felt by the nurses of the Baby Hygiene Association in dealing with children of pre-school age, who presented what have been called "behavior problems." To this clinic are brought children who are in the process of forming habits which, if persisted in, are so asocial as to handicap them for the race of life, and which, if not checked, will lead toward delinquency, dependency and crime.

One may ask why a clinic? Cannot a mother, by the exercise of a little common sense and wisdom, deal with the bad habits of her children herself? This may be answered by another question. Will the average mother be able to do so unaided? That it is the mother who must do the actual work is unquestioned, but she needs help. The child who requires specialized treatment is usually a little differently poised from other children, and faulty methods of management, which have no serious effect on

[7] "Child Mental Hygiene in Erie County, N. Y.," Aaron J. Rosenoff, *Mental Hygiene,* October, 1922.

the majority, spell ruin for the child whose nervous make-up demands a more careful handling. It is folly to instruct the mother of such a child about the proper diet for a boy of four, if we leave her helpless before the child's persistent refusal to eat anything that he does not want to eat, followed each time by a threat of vomiting that he is quite capable of making good. The wisest mother is at a loss under such conditions and requires medical advice as to the seat of the difficulty; and the average mother, even after diagnosis, also needs instruction if she is to teach the control which will change the young tyrant into a little boy who is building up a power of self-management that will control his whole future life.

In all such work the nurse's help is invaluable. Like every other form of preventive effort results will be difficult to tabulate, but if neurotic children receive sufficiently early and scientific attention there is small doubt that the effect will be a decrease later in cases of more serious trouble. Though as she progresses a nurse will undoubtedly give more and more time to children, in the beginning she will probably do well to place no limit to her sphere of action; and her work will include, in addition to such a constructive program as may be possible for the better care of children, the finding of adult patients and placing them under observation; the visiting and instruction of patients at the request and under the advice of private physicians; and the assisting at clinics where she can bring to the doctors the type of information regarding home conditions that will aid them in both diagnosis and treatment. She will be called upon to help secure hospital admission where necessary, and will also give such other assistance as the exigencies of the case require. She will visit, under the direction of the hospital doctors, paroled and discharged cases; she will study the various situations from her own particular angle, thus helping to create a better public opinion; and she will keep such records as will prove helpful for her own work and for a proper understanding of the problems involved.

To bring under observation new cases, whether of children or adults, two things are necessary: first, a nurse must be able to recognize mental and nervous disturbance when she sees it; and secondly, she must have free clinics or some substitute for them, to which she can bring her patients when found.

In finding new patients the usual channels of information may be used. Individuals of marked peculiarity may be reported to her by other nurses, by charity organization visitors or other philanthropic agencies, by physicians who do not themselves care to deal with the situation, by the family itself, or indeed by anyone who recognizes that something is wrong in a household. The nurse's first duty on receiving such information should be a visit to the home. The object of this visit is not to give general advice, but merely to ascertain whether or not someone in the family shows such symptoms of mental or nervous trouble as to make diagnosis of his case desirable, and if so to arrange that he see a doctor. In making inquiries great tact and circumspection will be required. It may be necessary to diagnose to the extent of deciding whether or not the reported case is really one needing medical attention. Beyond this a nurse must be careful not to go, and the requests of the family for an opinion must be met with the reply that only a doctor can give the desired information.

She must enter the house with an open mind, for such information as she has received may be quite misleading. Not infrequently the member of a family who complains of the peculiarity of a relative is the one who himself has the distorted point of view. On the first visit or visits it will be well, if possible, to talk separately with both the patient and another member of his family, though the natural disinclination of the nervously ill to be talked about must be reckoned with, and every effort made to avoid antagonism at the beginning.

At every visit a nurse must be on the lookout for cases of arrested development, and be prepared to find mental defectiveness where it has never been suspected. Many an incorrigible child has been cruelly punished in the vain effort of well-meaning parents to "beat sense into him," when as a matter of fact the poor little brain was incapable of getting sense, even by more scientific methods. Many a bright-looking girl of twenty has been morally ruined because no one knew that she had but the intelligence of a child of ten with which to protect herself from the dangers of city life. There are few public health nurses who have not had personal knowledge of a feeble-minded mother of an appalling number of illegitimate children. Such a girl comes

to my mind as I write, who at twenty-nine has had ten children, each with a different father. Maggie has a bright, rather attractive face and a strong, well-developed body, yet a mental test, applied after the birth of her tenth baby, showed her to have the intelligence of a girl of eleven. If at fifteen someone had recognized the poor child's undeveloped mind her history might have been a different one, and the city and a number of private agencies saved much unnecessary expenditure.

It is not only the defective child or young girl, however, who causes trouble. Every charity organization has history records which read like the following: "In 1905, Mary Ann, then the mother of four children, was the despair of the social agencies of the city. For years she maintained the semblance of a home, in wretched shacks usually approached through alleys. She lived a hunted sort of life, alternately abused or deserted by a brutal husband, foraging through alleys for food, and begging indiscriminately. The representatives of various social agencies tried to apply to her the laws and theories designed for the adult head of a family; thus the truant officer would exhort her to keep the four children regularly at school with threats of prosecution if she failed; the charity worker would pay her rent and demand cooperation in the form of a well-kept home in return; the probation officer would call and, revolted by the conditions of the home, threaten to "take her children away if she did not take better care of them." Mary Ann would clutch the last baby closer and look out in a scared way, and occasionally, when the ministrations of these well-intentioned agents grew too persistent, she would disappear with all her children for a period of several months."[8] It is unnecessary to follow Mary Ann's history through all its miserable details until she was finally brought into court on the charge of selling her young daughter to an Italian man. Had the record been dated in the second or third decade of the century instead of the first, it is probable that it would read differently, for at some point in many similar histories we now find the entry "Intelligence test shows mental capacity of a child of nine." How absurd to expect "cooperation" from a mother with the mind of a child of nine! Until more

[8] "Problems which the Mentally Subnormal Adult Presents to Social Workers," Amelia Sears, *Public Health Nurse Quarterly*, October, 1914.

effective work with children relieves this situation, each case of previously unrecognized adult feeble-mindedness must be dealt with to the best of a nurse's ability. It will require the cooperation of more than one agency to produce results, but the public health nurse should be a useful factor in coping with the difficulties.

In listening to the histories of patients there will be much chaff that must be blown away before that which is pertinent to the situation can be gleaned, but the trained ear will be quick to note such characteristics as reticence, seclusiveness, stubbornness, fads about diet, brooding sensitiveness and suspiciousness, when shown in connection with other oddities and strange behavior.[9] These are often the danger signals, displayed long before the occurrence of a breakdown, in the form of mental disorder called dementia præcox and disorders closely related to it. Such patients are usually unable to make the more difficult adaptations of life, and the breakdown is apt to come at a moment of unusual demand. As a rule it comes unexpectedly, for the simple reason that there has been no one to read the obvious signs.

Dr. August Hoch cites the following case in a pamphlet entitled "Early Manifestations of Mental Disorder." It is of a predisposed girl who began to show mental symptoms when she became engaged, but who was allowed to marry, thus precipitating a mental break-down. "The patient is a girl of twenty-two. She was not very bright at school; sometimes when the teacher asked her questions she gazed at her without answering. But on the whole she was not very peculiar, not decidedly unsociable. From the seventeenth year on, however, a change came over her, and she became more reticent and less sociable. Seven months before admission to a hospital she became acquainted with a man, is said to have become very much infatuated with him, and was engaged after a short acquaintance. Soon after this she began to show an indefinite fear, and, having lived away from home, she now returned to her parents' house. She soon developed fancies, and thought her fiancé might come after her with a knife. She had crying spells without saying why, was morose, and asked her sister to chop her head off. In spite of this plain beginning of a psychosis she was married some weeks

[9] "Early Manifestation of Mental Disorders," Dr. August Hoch.

before admission, and very soon got much worse and developed a grave psychosis from which she will not recover." Dr. Hoch goes on to say that the definite symptoms which developed at the time of the patient's engagement should have served as a warning, for they were of such a nature as to show plainly that they were connected with a lack of adjustment to the engagement, and a psychiatrist would have realized that she was utterly incapable of the adaptation demanded of her by marriage.

As it is estimated that the dementia præcox cases represent nearly a quarter of all the cases admitted to mental hospitals, it will be seen that a large field of usefulness opens to the nurse who tries to bring such patients under early observation and treatment.

The characteristics of paranoia are often found by the nurse in her daily rounds, ideas of persecution, a frequent change of occupation, a suspicious attitude at home. These patients may be harmless, but the case is probably showing progression, and early attention is important because persecutory delusions are always potentially dangerous. It is from this group of patients that we get most of the anti-social acts of the mentally ill.

A nurse must also be on the lookout for manifestations of the various forms of manic depressive psychosis. The symptoms of these psychoses usually show an exaggeration of normal emotions, and this of itself tends to obscure the situation from the lay observer. Care in an early stage of these diseases will often save untold suffering to the patient, for by such care later and more serious developments may perhaps be avoided. Many unheeded signs will be found if looked for, which indicate the trend of a mind that is silently contemplating suicide, and with no one class of patients has wise, kind and scientific treatment been more successful in an early stage. Relatives, as Dr. Macfie Campbell points out, usually take symptoms at their face value and find it hard to realize that a patient with a mild depression may commit suicide, or that another who is seclusive and embittered may suddenly commit a homicide. In such cases, where commitment is considered necessary by the doctor, a nurse can often be of great assistance in helping the family to a better understanding. There are other cases where recognition of the true situation will save relatives from depending on the unwise judgment of

a patient whose impaired mental condition has not been suspected.

In addition to the early manifestations of what later develops into actual psychosis, there are many forms of minor abnormalities that pass under the name of "nervousness," and which, though imposing great hardship upon entire families, are allowed to go uncared for, especially among the poor and ignorant. The nurse should be prepared to obtain a diagnosis for all cases showing marked tendencies to moodiness, unwise enthusiasms, odd attachments, suspiciousness, exaggerated timidity or anxiety, unusual interest in religious questions, an unhealthy feeling towards matters of sex, or other warped mental attitudes. That one or more of these tendencies exist in many normal people is, of course, true, as it is also true that a man may be living a normal life with a weak heart. We should, however, think the man with cardiac trouble unwise if he failed to have his heart examined, or if after examination he failed to follow directions laid down by his physician. Similarly many a nervous patient might be leading a normal life under slight supervision, thus changing the whole aspect of the world for himself.

Among those ignorant of nervousness the nervous member of a family is apt to have become one of two things, a despot and a tyrant who under the protective cloak of invalidism rules with a rod of iron because his friends are afraid of the results of crossing him, or a pitifully misunderstood martyr who learns to feel himself so great a burden as to long for the release of death. In either case the real situation, which is primarily one of disease, is not being touched, and the family that gives in to every nervous or selfish whim in order to avoid friction, or the one whose harsh misunderstanding causes such misery, are alike helping to push the patient down the hill toward more serious trouble. The authoritative voice of the doctor, aided by the detailed information given him by the nurse, is needed to help in each case to a right point of view. Often the first treatment for such patients lies in their temporary removal to another environment, and a vigorous training of their families; for an unmodified theory that a patient cannot control his nervousness, or that it is entirely within his control, is in either case fraught with danger to his welfare. As a matter of fact there is enough

truth in each theory to make the management of a nervous case one of the most difficult things in the world, but a wise, sympathetic nurse, working under the advice of a good physician, can do wonders to change insupportable conditions.

The tragedies and broken lives brought about by nervous or mental illness in any of their forms can never be estimated; and in doing her work the nurse, as with tuberculosis, must learn so to guide her sympathies as to protect the normal while she is helping the diseased, for as a public health nurse her duty is no less to the well than to the sick. In spite of the fact that the "germ theory" does not apply to nervousness, there is nothing more contagious, and the selfish demands of the nervous sufferer, or the unhappiness or peculiarities of the mentally ill, should not be allowed so to dominate a family as to cause the breakdown of others. From the patient's point of view, too, it is a recognized fact that strangers, even untrained strangers, are often better nurses for the nervous than the most devoted friend or member of the family, a fact difficult to be grasped by the uninformed.

A nurse trained in the care of mental and nervous diseases will have an understanding of the important part now played by occupational therapy in the care of certain types of cases, and though she should not herself become an occupational therapist such a knowledge may furnish the key-note for the beginning of treatment.

Good mental hygiene work is impossible without a free clinic. If no psychiatric clinic exists some temporary arrangement must be made by which the need for better or more permanent arrangements may be demonstrated. It has been proved that patients are glad to avail themselves of the advantages of psychiatric clinics, and once the need for help is felt by the patient himself, half the battle is won. Where it is possible to arrange for a number of small, well-served clinics, as at health centers, it is found that the people of the neighborhood readily make use of them. These should, however, either be under one management, or should work in the closest cooperation, in order that patients should not wander from one to another as the spirit moves them. Itinerant clinics are quite possible

in the country, and may be operated in connection with a county health unit.

The systematic visiting of paroled and discharged patients, whether done by nurses or hospital social service workers, is a form of mental hygiene work that has everywhere been attended with good results. The leap from the protected life of a mental hospital to even the most desirable normal environment is one that usually taxes a patient's powers of adaptability to the uttermost, and, as we know, the home to which he must return is often quite the reverse of desirable. There is as little common sense in returning a newly recovered patient to the exact conditions that caused his breakdown, as in returning a cured baby to the care of an uninstructed mother, who, in her ignorance, instantly resumes the injudicious feeding that so nearly caused its death. Visits of instruction to the patient's family before he leaves the hospital are important, for a great deal can be done by a wise nurse to prepare the way for his return to a healthy atmosphere.

The object of all treatment is the return of the patient to his normal environment in such condition that he will be able to meet, without assistance, the usual difficulties with which all men and women are obliged to cope in the ordinary routine of daily life. There must, however, be an intermediate stage between the complete protection of the hospital ward and a wholly normal and unprotected life. This the nurse must try to obtain for him, and his family and friends must expect to lend their aid for a time, quietly and simply, without apparent anxiety, until at last he can stand alone, normal again in his power of mental adjustment.

The future of mental hygiene work for public health nurses cannot be predicted. Ten years ago Dr. M. S. Gregory, Resident Alienist at Bellevue Hospital, sounded a significant note at the Mental Hygiene Congress in New York. He said, "Of course certain forms of mental trouble should be treated in the state hospital. However, the more I think of the matter, and as my experience increases the more I realize that for some classes of mental diseases hospital treatment may not be the best kind of treatment. These patients become, so to speak, institutionalized. The quiet and routine life of an institution tends

to the development of unhealthy physical and mental habits, and as life in an institution is so different from the outside world, they are unable to adjust themselves after their discharge. It would be more logical and profitable to treat such patients under normal and natural surroundings at home. I think the old Scotch method, as well as that applied in Cheel, Belgium, with added intelligent social service supervision, is preferable to state hospital care in certain types of mental disease."[10] The experience of the last ten years has confirmed this opinion. Dr. Thom tells us that of all the patients seen at the out-patient clinic carried on by the United States Veteran's Bureau in Boston, less than five per cent. were sent to hospitals for treatment.[11]

The preventability of mental disturbance is naturally a matter of great interest to all who are giving their time to mental hygiene work, and it is encouraging that the possibility of prevention is being increasingly recognized. That heredity plays an important part in certain diseases is unquestionable. Exactly what part has yet to be determined. That alcohol is responsible for certain forms of mental disease is also unquestioned; but to what extent its excessive use is due to an already weakened mental balance is hard to say, as so many chronic alcoholic patients are found to be psychopathic. To syphilis is due no small percentage of some mental disorders. Indeed it is considered to be the only indispensable cause of general paresis, but again only a small percentage of syphilitics succumb to general paresis, so that other contributing causes must be sought.

The practical application of the as yet but partially understood science of eugenics, the suppression of alcohol and the elimination of vice with its accompanying diseases, are large problems, insoluble in a day, or without the backing of a thoroughly awakened public sentiment. Yet the day is surely coming when an aroused public will understand the real significance of mental trouble, and will demand for all of its children such conditions as make for mental health, and for its sub-

[10] "Social Service in Preventing Mental Breakdowns," Dr. M. S. Gregory, Report Mental Hygiene Conference, 1912.

[11] "Results and Future Opportunities in the Field of Clinics, Social Service and Parole," Douglas A. Thom, M.D., *Mental Hygiene,* October, 1922.

normal and psychopathic children protection and a constructive program of education; when psychopathic wards will be common in general hospitals, and well-served clinics will be opened for all who need them; when nurses or social workers, or both, will be available in sufficient numbers to find new cases and to deal with those already found; when the medical profession will feel the same responsibility toward psychopathic conditions that it now feels toward other diseases; and when the old stigma attaching to mental disturbance will be relegated to a past age of ignorance, and only recalled as an interesting example of the world's progress.

The nurse who is playing her little part in this big forward movement is to be congratulated on the privilege of her opportunities.

Chapter 7

INDUSTRIAL

Though industrial nursing is usually ranked among the newer branches of public health nursing it is by no means a development of yesterday. An authoritative statement regarding its early history is somewhat difficult, but it seems fairly safe to assign the honor of its first establishment to the Vermont Marble Works which, in 1895, engaged a trained nurse to visit and care for sick employees and their families. Two years later the benefit association of the John Wanamaker Store in New York made use of the services of a nurse, who, though engaged to visit sick members for the original purpose only of securing a wise distribution of funds, quickly outran this limitation and succeeded in developing a service that fundamentally differed but little from the industrial nursing of today.

English industrial health work also dates from the last century, for the excellent health department of the Cadbury Company (chocolate manufacturers) was established in 1897. In both countries these examples were soon followed by other firms and corporations. As results proved the value of the work, development proceeded with increasing rapidity until at the beginning of the war industrial nursing had become common in factories, stores, office buildings, mining villages, and in fact wherever men and women were employed in large numbers. With the war came a tremendous impetus. All public health nursing was of course profoundly affected, but in the industrial field the effect was peculiarly obvious. In every plant continuous and vigorous output became of prime importance, and medical and nursing services, organized to increase health and prevent loss of time, were valued accordingly. With every factory running at full capacity, with countless new business enterprises springing into existence, and with an enormous increase in the number of women and girls employed, it was natural that industrial nursing should share in the general expansion.

The period of economic depression that followed the war

presents a very different picture. Soon after the signing of the armistice unemployment began. Thousands of mills and factories ran on half time, others were closed entirely, and in almost all of those running at all the number of employees was greatly reduced. Many of them gave up the nursing service as part of the general scheme of reduction, and a number of those that were temporarily closed failed, on reopening, to reengage their nurses. In consequence industrial nursing has passed through a period of eclipse unknown to the other branches of public health nursing and from which it is only now beginning to emerge.

The industrial field has always been unevenly tilled, and in consequence standardization has lagged. Though many firms have an extremely broad vision of the possibilities of the work, and require for their nurses well-prepared women who will share this point of view, others desire nothing but the duties of the first aid room; and for these they have too often engaged women of narrow outlook and, in not a few instances, of questionable professional preparation. The lack of supervision that is ordinarily provided for other public health nurses has also been a factor making for unstandardized work, for in industrial nursing new nurses must often start work alone with no supervision at all. At one time a hopeful solution of this problem seemed possible through the affiliation of industrial concerns with local public health nursing organizations, the latter furnishing nurses, and maintaining supervision over them. Though this arrangement has worked fairly well in a few instances, it has not apparently met with general satisfaction. The additional slight expense entailed has in some instances been a stumbling-block, but the principal causes of failure have seemed to lie in the objection of the management to any outside control, and in the fact that public health nursing organizations have not been sufficiently familiar with the problems of the industrial field to prove truly helpful in supervision.

In considering industrial nursing it must be remembered that the term covers many types of activity. The work naturally differs with the type of plant in which it is done, and it is also affected by the source of its support and the form of organization under which it is maintained.

Three methods of support and administration are possible. The entire responsibility may be borne by the employer who furnishes funds and controls policy; the employees themselves may assume this responsibility through group association in a single plant or through a labor union; or responsibility may be shared by the employer and the employees each contributing a part of the cost, and each having a voice in the administration.

The industrial worker is as a rule extremely self-reliant and prefers a method by which he has a share in the maintenance of the service and a voice in its policy. Where this is the case a nurse is usually responsible to a committee of workers, or one on which the workers have representation. The opportunities afforded by the meetings of such a committee should be highly esteemed by every industrial nurse, and time and thought given to preparation for them. Indeed committee meetings of this type have much in common with the board meetings of any public health nursing organization, and should be valued quite as highly, offering as they do opportunity to preach the doctrine of preventive and educational health work.

An industrial nurse, though she may be a pioneer, usually starts her work under favorable conditions, for a sympathetic attitude is implied by the very fact that a company or group of workers desire her services sufficiently to pay for them.

Many motives enter into every action, but though a few employers have doubtless been influenced in the establishment of their service work by the thought of advertisement or a desire to escape criticism, it is safe to assign to the great majority two chief motives: a genuine desire to better the conditions of their employees, and a recognition of the general principle that efficiency of service is secured by the health of the workers just as it is secured by the good condition of the machinery employed.[1] It goes without saying that where insufficient wages are paid and working conditions are unnecessarily bad, a department established to benefit the employee is an anomaly, and will

[1] Mr. George M. Price assigns four motives for employers' welfare work: first, the philanthropic motive; second, fear (fear of labor unionism, radical socialism, labor wars, etc.); third, efficiency; fourth, industrial justice. The last motive Mr. Price believes to be constantly gaining ground among the better class of employers. "The Modern Factory," George M. Price.

be built on too insecure a foundation to endure. Without the requisites of industrial well-being, steady work, a living wage and healthful working conditions an industrial nurse will have an uphill road to travel, though she may well remember that the poorest situations sometimes offer the best opportunity for service and the greatest hope for improvement.

An intelligent nurse will naturally wish to inform herself of methods of industrial welfare work as carried on elsewhere, and it will also be well for her to make some study of conditions governing the special industry with which she is connected. It seems hopeless to suggest that she should try to understand the complex problems of the present general industrial situation. The whole labor question is so involved, and so many side issues affect the problems, that there is danger that a little reading will only prove confusing. A thoughtful nurse should, nevertheless, know enough to be aware that she is in touch with many more forces than meet her eye in her immediate work. If she is of the type to whom study of this kind is enjoyable, she may add greatly to the interest of all that she is doing by well-selected reading, but she must beware of forming unripe opinions or jumping to hasty conclusions after having read half a dozen books. Any reading should be done with a view to getting a glimpse of all of the various aspects of the subject, and the books selected should, therefore, not be confined to a single line of argument.

An industrial nurse should keep consistently out of all controversies between workers and employer, whether these be simple matters of local adjustment or the larger issues dealt with by the big labor unions. Unless she adheres rigidly to this rule, she will find herself entangled in a thousand complexities that will inevitably lead to an end of her professional usefulness. One of the most invaluable assets of a nurse engaged in such work is her almost unconscious power to interpret the employer to the worker, and *vice versa*. This she will not be able to do unless she keeps free of entanglements, and unless she really sympathetically understands the attitude of each. Therefore to the acquisition of such understanding she must apply every effort. She will of course form her own independent opinion on many points, but wisdom will counsel reticence.

Before undertaking new work alone an industrial nurse should, if possible, seek special preparation for it. Courses in industrial nursing are sometimes offered in connection with the regular public health nursing courses of colleges and universities. If such courses are not available or cannot be taken, it is highly desirable to serve at least a short apprenticeship in a subordinate position under a nurse of experience. When work must be undertaken without these advantages, we can only counsel careful perusal of the literature of the subject,[2] and such association with other nurses as local conditions permit. A nurse working alone will need to bear constantly in mind the danger of deterioration in all unsupervised effort, and must set herself resolutely to combat this tendency by continually measuring her work by the standard of that of other women of her own profession. Without the double stimulus of approbation and criticism that is a part of all supervision, it is difficult to avoid, on the one hand, undue discouragement, and, on the other, that easy satisfaction with partial accomplishment that is death to better things. It is not enough to satisfy an employer who is in all probability unfamiliar with the finer technicalities of public health nursing. Real and lasting success can only be attained by the nurse who also conforms to the highest standards of the nursing profession.

Before accepting a position it is well to have a thorough understanding on a few important points. A nurse should know to whom or to what committee she will be directly responsible; if the plant has a welfare or medical department, she should know what her own relationship to it is to be; she should know what quarters will be provided for her work; she should have exact information regarding hours and salary; and, most important of all, she should know very definitely what arrangements have been made for medical service, in order that she may be sure that she will not be expected to take the place of a doctor. If she has been engaged through a personal interview, it will

[2] "Industrial Nursing," by Florence Swift Wright, is a mine of valuable information that has been freely drawn upon by the author in writing this chapter. *The Public Health Nurse* frequently publishes articles on the subject and there is also much current pamphlet literature dealing with allied topics.

be as well to recapitulate these points in a brief letter, a copy of which with the answer may be kept for reference. It is also wise before beginning work to have an interview with the individual under whom the position is actually to be held. A short talk before final acceptance often prevents future misunderstanding and friction.

Broadly speaking, four types of work come within the scope of industrial nursing: first, care and advice given the individual employee at the plant; second, collective health teaching and a general responsibility for sanitary and hygienic conditions; third, home visiting for purposes of instruction and to render nursing service; fourth, the inauguration of community health work when the plant is situated in an industrial village or small town.

The *first* duty, that of giving care and advice to individual patients at the plant, is usually entered upon by way of the first-aid room. Here much will depend upon the arrangement for medical service made by the company. Some have built up well-developed medical departments with doctors in daily attendance, and a nurse will find herself part of an organized group of health and welfare workers. Other companies employ doctors for part-time work, and still others make special arrangements for the services of physicians only when needed. Varying methods also obtain regarding the degree of responsibility for health conditions assumed by the employer. Some companies which require a physical examination of all employees do so merely for the purpose of the exclusion of the unfit. Others offer very complete examination and re-examination to everyone, results being recorded and used to effect an improvement in individual health.

Whatever the arrangements for medical care may be, a nurse should be assured that her own professional duties are clearly defined, for she must guard against even the semblance of an undue assumption of responsibility. Indeed, there is no reason why an industrial nurse should carry any responsibility not usually assumed by other public health nurses. Temptations to diagnose and prescribe abound, but they must be withstood; and if dressings and the prescribing of simple remedies are expected, standing orders must be issued and a very clear understanding

arrived at with the doctor regarding the exact limitation of responsibility for such service. When more than one doctor is employed, confusion will be avoided if the standing orders can be made uniform. This can usually be accomplished by a request from the nurse for a joint conference on the subject. On the whole, the less that is done in the way of medicine-giving by a nurse the better. Only the mildest alleviatives will come within her province, and the value of these is very slight compared with the type of advice that will make for more healthful ways of living.

The extent of the medical service offered differs greatly with different companies. Some arrange for an unlimited call upon the services of the company physician, others expect employees to consult family physicians except in emergencies. With these varying conditions a nurse will naturally make herself thoroughly conversant.

In very large plants a certain amount of decentralization of the first-aid work is necessary, and first-aid stations are distributed throughout the works. If nurses are not supplied in sufficient numbers to staff these stations, one employee in each department may be made responsible for immediate action in case of accident until doctor or nurse can be summoned. Though not an ideal method, such volunteer assistance is useful, and ability of the type required can usually be found, for every large group of men or women includes one at least who comes to the fore in times of emergency and proves naturally helpful. The trouble generally lies in a too great eagerness and haste to do something. Few accidents require instant action, as a nurse will have ample opportunity to demonstrate by her own calm and deliberate demeanor.[3]

If the workers themselves are relied upon for first aid in

[3] "Instant action is only necessary in two conditions: first, profuse venous or arterial hemorrhage; and, second, arrested respiration from drowning, electric shock, or asphyxiation from poisonous gases, pressure on the throat or foreign body in the larynx. The more serious first-aid problems are simple if a nurse remembers four points: first, treat profuse hemorrhage instantly; second, treat arrested breathing instantly; third, treat shock promptly; fourth, do not wash extensive wounds or remove clots, cover with sterile gauze or clean material while waiting for the surgeon." "Industrial Nursing," Florence Swift Wright.

emergency, the nurse (unless a doctor assumes this responsibility) must be sure that the necessary supplies are at all times in place and in proper condition, and that the individual selected to take temporary charge understands what to do, and, equally important, what not to do. For her own peace of mind, the nurse should also know the exact method of procedure in case of accident, leaving no detail to be worked out in the confusion of the moment. She should, for instance, have an understanding with the management what doctor is to be summoned in case the company surgeon cannot be reached, or what ambulance to call if the patient is to be sent directly to the hospital. After an accident certain persons connected with the plant must be officially notified, a routine duty that may be delegated to the nurse. It is also a great help to the friends of the patient if time can be found to see them and explain the actual situation. Much suffering is caused by garbled accounts carried home by uninformed or misinformed fellow workmen who know nothing of the actual situation.

Such dramatic moments are, however, fortunately rare, and for the most part a nurse's time is spent in less exciting and more constructive work. It will usually be found that previous to the establishment of a first-aid room for dressings the number of industrial injuries has been small. This means that unimportant injuries have failed to receive attention unless serious consequences developed. An employer is apt to be surprised at the increase of reported injuries that follows the opening of his first-aid room, but inquiry never fails to show a corresponding decrease in the number of infections. In considering the value of first-aid service he will do well to examine statistics regarding loss of time, surgical expense and settlement claims resulting from this type of trouble. In addition to minor injuries, the care of which the doctor is usually glad to turn over entirely to the nurse, there are other dressings which have received his attention but which are sent back to the first-aid room for daily care under his general oversight. There are also a certain proportion of medical cases, some of them simple conditions of discomfort requiring rest or the mere application of heat or cold, and others of a more serious or more acute nature.

Every nurse, whether connected with a medical department

or not, should have an office of her own where privacy may be secured for interviews with her patients. Though it is sometimes necessary to manage with one room, wherever possible there should be, in addition to the office, a small room for surgical dressings, a waiting room, and a rest room. Where both sexes are employed, two rest rooms are desirable. If such arrangements are out of the question, the waiting room may be sacrificed and the patients allowed to wait in the hall. The dressing room is also sometimes used for a rest room as well, though this is undesirable. Provision should be made for a supply of hot water and also for sterilization, not a difficult matter in manufacturing plants where live steam is available. Records should be kept in locked cabinets. The nurses' quarters should be a model of cleanliness and order, with, if possible, a touch of added attractiveness given by a few growing plants, pretty washable sash curtains, or other trifling additions that will not be at variance with the true purpose of the rooms.

In industrial nursing, as in all other types of public health nursing, publicity is necessary if the nurse's work is to be brought to the attention of those whom she is prepared to serve. Publicity may be accomplished through notices placed in the pay envelopes or posted in conspicuous places throughout the plant. Some concerns allow the nurse to talk with the new employees engaged each day, thus enabling her to explain her work to everyone. Frequent visits to the work rooms are helpful, not only in enabling the nurse to acquire a first-hand knowledge of working conditions, but also in making her a familiar figure to employees. It is desirable also that the nurse's services should be used by everyone connected with the plant, from the manager to the newest employee. If this is done the work will be more quickly popularized, and the possible fear of paternalism removed.

Accessibility is an important factor in the success of a nurse, and this will depend on several things. In the first place, her office should occupy a conspicuous position and one convenient to reach. If her own personality inspires confidence, the workers will be drawn to her, but unless their coming is made easy she will only get the more obvious cases. The attitude of superintendents, foremen or floor walkers who refer cases to her is

important, as is also the question of whether employees are permitted to come to her during work hours. Nothing, however, is more important than the value placed upon her work by the workers themselves. Many men feel that attention to slight injuries, or the reporting of seemingly unimportant symptoms, is silly and useless, and stamp men who submit to such attention as unmanly. It is not unmanly to protect a slight injury from infection, or it would not be so vigorously insisted upon in the army. Nor is it unmanly to try to discover the cause of a pain that may be an early symptom of a serious trouble. On the other hand, everyone is familiar with the type of young person to whom nothing is more delightful than a long discussion of their mental, moral and physical selves. This type of man or woman, boy or girl, a nurse must train herself to recognize, as she must recognize the workers who too readily avail themselves of the opportunity to break the routine of duty by a trip to the nurse's office, or an hour in the rest room. Where piece work is done, there will be less of this, but an industrial nurse must bear in mind the money value of time during working hours, and must assist both the company and the workers to avoid waste.

In all her efforts to reach the employees a nurse should work through recognized channels. If foremen or floor walkers are expected to send the workers to her, she will effect a much stronger organization by educating them to do so than by becoming discouraged over a few failures and attempting irregular ways of bringing patients to her office. If after an honest trial she find any given method of procedure unsatisfactory, an appeal to the right authority will frequently put the matter straight.

Much of a nurse's office time will be spent on personal advice regarding healthful ways of living outside of working hours, and she must not fail to enter into such details with those coming to her for help. The girl who asks for a pill to cure indigestion often needs in reality a long course of instruction on the proper method of feeding herself, before she can be persuaded to replace the ice-cream soda, taken after she arrives at the store, by a suitable breakfast eaten at home. Behind the nervousness that brings another girl to the office may lie a whole tragedy of home

difficulty, or perhaps merely a love of gaiety indulged in at the expense of necessary sleep. An understanding of these individual situations, and a little wholesome advice as to such simple things as food, sleep, recreation, or the way of spending a vacation, may be enough to tip the scale to the side of health. More and more are public health nurses learning that ignorance and carelessness weigh just as heavily as poverty on the lives of their patients, bearing them down to sickness and ruined constitutions.

A nurse will find it expedient to keep her office open and to be herself at leisure during the noon hour, for it is then that advice and help are most frequently sought. If this is done, another hour should be taken for the nurse's own lunch.

The detection of cases of contagion is an important part of an industrial nurse's responsibility, both for the health of the workers collectively and for the welfare of the individual. She should constantly be on the lookout for early symptoms of every form of contagious disease, and should be able particularly to detect and bring to the doctor's attention cases of suspected tuberculosis while there is yet hope for the patient's recovery, and before others have had time to become infected through his carelessness. In times of epidemic it will be impossible for a nurse employed in a large plant to see and inspect every employee. The duty of inspection must therefore be delegated to others, and a routine procedure instituted by which all workers presenting suspicious symptoms may receive attention.

Great changes have taken place in the minds of students of public health as to how contagion is carried. It has been pointed out by such pioneers in modern public health work as Dr. Charles V. Chapin that many of the terrors of earlier days, leaky plumbing, soiled clothing, foul air, garbage, bad smells, etc., though certainly undesirable from every point of view, are still innocent as a means of spreading contagion, which is in reality carried only through direct contact with infected material thrown off by the patient, or by means of certain recognized carriers such as the louse, the rat, or the mosquito. If a nurse is a graduate of some years standing she must make herself thoroughly familiar with these more modern theories before attempting work that deals with large groups of people necessarily thrown

together for many hours each day. She should also be familiar with the laws affecting industrial conditions, the prescribed working hours for women, the minimum number of cubic feet of air required per person, the laws governing the work of children, etc., etc.

A certain amount of time must also be spent in educating people to a proper use of the health arrangements made for them. Sanitary cuspidors are of no value unless they are used. Nothing has been accomplished by the installation of a pure water supply if a nearby tap of bad water is used instead.

Cleanliness, as we all know, cannot be achieved unless all do their part toward its maintenance. Time is well spent by a nurse who succeeds in inducing men who work at such trades as dipping or grinding, to wear glasses for the protection of their eyes, or in making popular the use of special shoes for moulders who are so often incapacitated by burned feet. If her patience sometimes becomes exhausted by the lack of interest displayed in such things, she must remember that comprehension of the more subtle laws of cause and effect implies a considerable degree of intelligence.

Because an industrial nurse's work is apt to be unfamiliar to those by whom she is employed, she is sometimes tempted to make much of the more effective elements, laying insufficient stress on the equally valuable, but less dramatic, preventive efforts on which so much of her time is rightly spent. Her professional helpfulness in giving first aid to the injured, though perhaps most telling in demonstrating her ability to command a difficult situation or possibly to save a life, is no more valuable than the time she spends so prosaically in persuading the workers to take a few simple precautions for the care of their health or the avoidance of accident. There is much to tell of the critical case of pneumonia nursed back to health by the skill of the nurse, and little to tell of the incipient cold discovered and cared for before the lungs were affected. But every public health nurse is too well versed in the doctrine of prevention to need any reminder of its importance. We would merely urge that the industrial nurse make this point equally clear to those among whom she works.

As has been aptly said, employees must of necessity be thought

of collectively. It is a nurse's duty and privilege to think of them individually, and she can often be extremely helpful through effecting a change of employment for those who are handicapped by some physical disability which makes certain forms of work undesirable.[4] To do this she must be sure of her facts, both in regard to the patient's condition and the work that he is doing. Usually there will be little difficulty if the matter is taken up in the proper way, and if she has succeeded in establishing a reputation for good sense as well as a kind heart.

The individual social problems encountered by an industrial nurse will not differ from those of other public health nurses, and must be dealt with in the same way, by personal advice and through cooperation with other agencies. To attain her greatest usefulness, therefore, an industrial nurse must be supplied not only with wisdom and good judgment, but with a thorough working knowledge of the resources of her community. A young girl may need advice regarding a boarding place; a boy an introduction to a boys' club; a man, assistance in securing reliable legal aid; or an old woman, admission to a home; and with such situations a nurse will be powerless to deal except through intelligent cooperation.

The question of relief will inevitably arise. Three forms of relief organization are to be found in industrial work: benefit organizations maintained entirely by employees, organizations maintained by employers, and organizations mutually maintained by both employees and employers. A patient should never be referred to any relief-giving agency without his knowledge and consent. In many plants there is someone in special charge of such matters whose sanction must also be obtained. It is universally felt that a nurse should not herself dispense material relief, though she may without objection take a salary or sick benefit allowance to a sick patient.

The *second* responsibility of the industrial nurse, that of col-

[4] Nurses sometimes undertake the duties of employment management, a field of service offering excellent opportunities for the right woman. For this work special preparation is necessary, either by means of the courses offered in the various colleges, or through an apprenticeship in industrial work that will give the necessary background.

lective health teaching and the giving of advice on matters affecting the general welfare and comfort of the employees in the plant, is more difficult for the average nurse than the care of the individual. If she works in collaboration with a social worker she will have to deal only with conditions very obviously affecting questions of health. If she works alone a much wider field of responsibility will be hers.

Many methods have been used to bring the subject of health interestingly and convincingly before large groups of men and women. For a time the so-called health drives were extremely popular, but of late such whirlwind methods have fallen somewhat into disrepute. More faith is now pinned to the educational influence of steady and continuous effort. Health talks, if well given, are good, and time is sometimes arranged for these during work hours. If this is not the case a portion of the noon hour may be used for this purpose. When the responsibility for arranging these talks falls to the nurse she must take great pains in the selection of her speakers, and for those that she gives herself she must take ample time for preparation. She should learn the art of being both brief and interesting, for no audience, least of all an industrial group at lunch time, suffers dullness and verbosity with patience. Health literature, if thoughtfully and not too profusely distributed, is also helpful.

A nurse must be reasonable in her efforts to improve conditions in the plant. If she is working in an old building she must recognize the limitations involved, and be prepared to meet the management fully half way in improvising and making the best of unsatisfactory arrangements. If the changes she contemplates are many, she will be wise to make her requests strictly in the order of their importance, giving her reasons for each and possessing her soul in patience regarding all non-essentials. For her own immediate work she will need, as we have seen, suitable office space and equipment. She will need also a simple but adequate record system, and a workable method of bringing her services to all of the employees who need her either for actual care or for instruction and advice. She should try to secure for the workers conditions conducive to health and safety: proper systems of heating, lighting and ventilation; clean and decent sanitary arrangements; an accessible

supply of pure drinking water; safety devices for protection from accident, dust or dangerous fumes; suitable rest rooms, etc. She may go farther and use her influence toward the establishment of comfortable lunch rooms where subsidiary hot meals may be served at low prices, and she may interest herself in the installation of good locker rooms, shower baths and other conveniences that will add to both the comfort and well-being of the workers.

Day nurseries have been established by some industrial concerns, where the children of employees may be brought daily while their mothers continue work. The establishment of a day nursery, however, in connection with a factory is of questionable desirability, because the mothers of young children should have no place in such an industry. Employment that takes them away from their legitimate task of caring for their children is not wisely encouraged. Nor does their record of output of work usually compare favorably with that of other women. For the same reason the advisability of maternity benefits may be questioned. Though provision is usually made for a cessation of work before the baby's birth, and a period of rest after confinement, they undoubtedly tend to keep women in industry at the expense of their more important duty of child rearing. If a day nursery is established and is placed under the general supervision of the industrial nurse, she must inform herself of the most approved methods of day nursery management, for unless very carefully conducted, a day nursery becomes a center for the dissemination of contagious diseases. In many ways supervised boarding houses are better, though as we have already said any plan is a makeshift that provides for other than a mother's care for a young child, and should always be so considered.[5]

The *third* responsibility, that of home visiting, is by no means universal, but many industrial nurses consider it of great importance if a good piece of health work is to be done.[6] It is, how-

[5] Provision for mothers' pensions, usual in the majority of States, should have an effect on this question.

[6] Some Canadian firms consider home visiting of such importance that first-aid work in the plant is done by supervised volunteers in order that the nurse may be released for home visiting.

ever, sometimes impractical if the homes of the employees are widely scattered and at great distances from the plant. Home visiting may be done in two ways, by special nurses employed by the plant itself, or through an arrangement with a local public health nursing organization, payment being made either on the visit basis or through an annual payment based on the number of workers employed.[7] The former method has certain advantages in the maintenance of a somewhat closer relationship between the firm and the employee, but if the services of a good public health nursing organization are available it is on the whole better to make use of them rather than to multiply agencies and duplicate effort. When there is no such arrangement and payment is not made for such service either by the firm direct or through group insurance, a patient will naturally pay for his own nursing care by a private agency according to the usual rates of the organization giving it. In these circumstances the industrial nurse must be careful to explain the situation, in order that misunderstanding on this point may be avoided.

Home nursing supplied by the firm usually implies the employment of more than one nurse, in which case nurses may alternate in working in the homes and in the plant, thus familiarizing themselves with all the problems involved. The home visiting of the industrial nurse differs from that of other visiting nursing only in that her ministrations are confined to the families of the employees of the firm or company which she represents. If a man changes his work while sickness is in his family, and the services of the industrial nurse are necessarily withdrawn, it is then her duty to see that the case is duly turned over to the local public health nursing organization, or, if none exists, that provision is made if possible for future care.

It is the custom in some plants for the industrial nurse to receive a daily list of absentees on whom a routine visit of inquiry is made. Such visits are a waste of a nurse's time unless sickness is suspected, and will do positive harm to her work if made for detective purposes. A nurse has no responsi-

[7] The group insurance policies issued by certain insurance companies and carried by a number of employers offer home nursing through local public health nursing organizations.

bility whatever for malingering, and will only weaken her professional usefulness if she allows herself to assume it.

The *fourth* and last responsibility falling to the lot of the industrial nurse, that of inaugurating community health work, applies principally to the nurse who works in an industry operating in a village or small town. Not infrequently a single industry is responsible for the existence of the village that has grown up around it, and the establishment of a community health center is a logical outcome of other efforts to secure satisfactory living conditions for the workers. Where an extensive welfare service is maintained a nurse's work will be part of a larger social and medical program, including clinics, teaching, recreation work and the usual activities of a social settlement. In this case she will probably carry on her own branch of the work from the common center. In starting any community health activity in a town or village in which the employees of the industry represent but a part of the population, a nurse must be careful to undertake nothing that means duplication of effort, and nothing that will hold back a broader progress.

Health work is sometimes carried on from a company hospital, the industrial nurse having her headquarters there and using the hospital as a center for her health work. In isolated communities where other accommodation is wanting a hospital maintained by the industry may be necessary. Wherever possible, however, it is considered better to strengthen the local hospital by making use of it.

In considering the trend of industrial welfare work a question naturally arises as to the attitude of the Trade Unions toward it. It might, perhaps, be described as one of watchful waiting. Not unnaturally the Unions fear the effects of slight reforms which will serve as a cloak to hide the abuses of long hours or low wages, but J. W. Sullivan of the Typographical Union and a member of the Federations Public Ownership Commission, in speaking to the Home Economics Club, Teachers College, Columbia University, upon the Trade Unions' attitude toward welfare work, opened his address by saying, "The Trade Unionists are observing sympathetically the National Civic Federa-

tion's Welfare Department and its work is upheld by those who understand it."[8]

The industrial nurse still has her way to make among both the employers and the employed. The former do not always recognize her need; and for the latter the intangible value of health protection is somewhat remote, unless it is first brought home in some very practical form. Her work, however, is so simple and sane, and her service so evident, that her eventual establishment on a permanent basis seems assured.

[8] Pamphlet, "The Trade Unions' Attitude Towards Welfare Work," J. W. Sullivan.

Chapter 8

VENEREAL DISEASE

Venereal disease work as a definite branch of public health nursing is comparatively new. As with tuberculosis and mental hygiene, advanced cases of various types have always come under nursing care, as have also cases of ophthalmia neonatorum. Until the war, however, there was no country-wide constructive program for the control of these diseases and, except for such work as was done with gonorrheal eyes, there was little to stimulate a nurse's interest beyond an individual case.

The draft figures and the necessity for maintaing a fit army aroused the country to an appreciation of the prevalence of venereal disease. A very definite program for its control was inaugurated, and it was as a part of this war program that the public health nurse first seriously entered the field.

As in other forms of public health work in which actual nursing care is not a first requisite, the question frequently arises as to the relative advantages of the employment of nurses and social workers. Both are already in the field, often working side by side, for though many venereal clinics are served by nurses alone, and others by social workers alone, there is a third group making use of both nurses and social workers together. This last arrangement sometimes works extremely well, the duties of both types of workers being so correlated as to bring to each enough responsibility of a constructive nature to stimulate progressive interest. This is not always the case, however. There is sometimes a tendency to relegate to the nurse a very narrow sphere of action, and only those duties that are considered strictly nursing in character, such as attendance on the doctor in giving treatments, and a certain oversight of the physical condition of individual patients. While the importance of such service is not questioned, that is not public health nursing; and were this the nurse's only part in the campaign against

venereal diseases, a chapter on the subject would find no place in a book of this type.

As a matter of fact, venereal disease work does not differ from any other form of public health nursing except in regard to questions of detail. The same general rules of procedure apply to it, and the same breadth of view must be maintained, if effective work is to be done. Perhaps, however, there is no type of case toward which it is so difficult to acquire a right attitude of mind, and none toward which it is so essential. For years, indeed for centuries, the venereal diseases have been shrouded in a veil of secrecy and concealment that has made any adequate handling of them as medical problems impossible, and until recently even the medical and nursing professions have been quite unprepared to deal with them in their relation to general public health. This is undoubtedly because the issues of venereal disease as medical problems have for so long been confused by their association with the moral problems of vice and prostitution, an association that has prevented plain speech and straight thinking. Because about half the cases of gonorrhea and syphilis that enter the clinics are due to immorality, it has been felt that these diseases could not be treated in the same way that other diseases are treated. There has also been in the mind of the public a lurking feeling that perhaps it is just as well to allow men and women to reap the just reward of ill-doing, in the hope that if that reward is sufficiently rich in misery it will act as a deterrent for themselves and others.

A little thought must make plain the folly of such reasoning. Even were it conceded that a lifetime of intermittent suffering and the possibility of a death of slow deterioration is a just sentence for the offence, are we justified in exposing a whole community to the dangers of a contagious disease merely to punish an individual? Also such justice is likely to be extremely haphazard in its effect, for owing to the peculiar nature of venereal disease one offender pays to the uttermost limit, while the next goes unscathed to laugh at the possibility of danger. And what of those innocently infected? Are we to discriminate in dispensing medical and nursing service, giving care only to those who are considered "deserving"? Just so long as venereal disease is looked upon as a punishment for sin, just so long

shall we endure its ravages, but fortunately a day of saner thinking is dawning, and however difficult the task of eliminating these diseases may be, we are at last on the right road to its accomplishment.

There are many aspects of the venereal disease problem, and it is unwise for any one individual to try to attack them all. No nurse need lower her moral standard or believe less ardently in purity and clean living because she leaves to others the task of the moralist and gives her time to that of the sanitarian. Anyone who is doing such work will naturally feel a keen interest in all that makes for a better community life, and especially in those things that most nearly affect her own problem, as, for instance, provision for adequate opportunities for healthy recreation, training of children in habits of self-control, efforts to secure a saner and better understanding of sex questions, a just wage for women, proper safeguards for young people through supervision of public amusement places, suppression of prostitution, all, in short, of those efforts now so common to avert danger and increase the opportunities for normal healthy human existence. Nevertheless, in spite of these wider interests, as a health worker, a nurse is chiefly concerned with syphilis and gonorrhea as contagious diseases that attack the individual and devastate the community, and any efforts toward reform that detract from her power to deal with this medical aspect of the situation should be left to others, and not allowed to interfere with what for her is the main issue, the medical problem involved.

Full descriptions of the venereal diseases will be found in any good medical textbook. Here no attempt will be made to discuss them, except in their relation to the field of public health nursing. A few words, however, in regard to those elements that make them so difficult as health problems may not be amiss.

They are usually accounted three in number, syphilis, gonorrhea and chancroid.[1] Chancroid can be dismissed with a word because as a rule a nurse, except in the routine of bedside care, has little to do with it. It is an infective ulcer, which, while it may do much local damage, remains local and does not affect

[1] Gangrenous balanitis is sometimes included as a fourth venereal disease.

the body as a whole. Syphilis, however, may be suspected where chancroid is present.

Syphilis[2] has been considered as old as Biblical days, and was supposed to be more or less confused with leprosy in the early writings. In all probability this is a mistake and syphilis was unknown to history until after the discovery of America, when Columbus and his sailors brought it home with them from the Island of Haiti. The havoc wrought by a contagious disease on a people hitherto unexposed to it, and therefore without immunity, is well known, and syphilis spread like wildfire through England, France, Italy and Spain, reaching eastward into Asia and pursuing its course through India, China and Japan. This terrible epidemic which spread devastation through so large a part of the world was a far more violent, far less subtle foe than the syphilis of our own day. It attacked and killed in dreadful ways, but it killed, so to speak, in the open. Syphilis, as we know it now, rarely kills in its first attack, but in its own inconspicuous way it is responsible for an incalculable amount of harm to the human race in all parts of the globe. Its power of latency is one of its most marked characteristics, a power that more perhaps than anything else has made this disease the problem that it is.

Three stages of syphilis have long been recognized, the primary, the secondary and the tertiary stages, though with an increased knowledge of the actual course of the disease the old conception of a sharp division of these stages, based on outward signs, is considered too arbitrary.

The average period of incubation is two or three weeks, though it is sometimes as short as a week and may be prolonged to two months or more. Incubation ends with the appearance of a primary lesion, and this is the dramatic moment in the cure of syphilis. If it can be diagnosed and treated at this point recovery is practically assured, because for a short time after its first appearance the germs are localized and with the prompt employment of Salvarsan and what is known as the abortive

[2] For the following description of syphilis and gonorrhea, the author is largely indebted to that remarkable little book, "The Third Great Plague," by John H. Stokes, M.D., and also to the same author's Government publication, "Today's World Problem in Disease Prevention."

cure, the chances for complete recovery are very nearly one hundred per cent. This period, however, is extremely short and, because the primary lesion usually causes little or no discomfort, it is easily overlooked. This amounts to little less than tragedy, for treatment is not only important at this time on the patient's own account, but is of vital importance from the point of view of contagion, because with a proper use of Salvarsan infectivity may be assured. Certain modifications of the original idea of the efficacy of Salvarsan have been found necessary. It was thought at first that, because of its remarkable power to kill the spirochetes, a single dose given at the right moment would immediately effect a complete cure. This has not proved to be true, however, and continued treatment with both Salvarsan and mercury is required if more than temporary results are to be assured.

The secondary stage is by no means so simple, though even at this stage life is rarely endangered, nor is there as a rule much suffering. The germs, no longer localized, are distributed by the blood in enormous quantities throughout the entire body, usually causing a characteristic eruption which alarms the patient and brings him to the doctor. A rash, however, is not always present, nor can any constitutional symptoms be counted upon, though there is apt to be headache, slight loss of weight and pain in the bones. A few patients are seriously ill, but with the greater number constitutional symptoms are mild, and with many so mild that they escape notice entirely.

It is, however, during this secondary stage that the majority of patients consult a doctor and consequently come into the nurse's hands, and it is at this point that treatment is most often begun.

Two powerful drugs are relied on for the cure of syphilis, Salvarsan (606)[3] and mercury. Both seem possessed of magic powers: Salvarsan, a combination of arsenic and other chemical substances, acting as a quick and deadly poison for all the germs in any open lesion; and mercury acting more slowly but more

[3] So called because it was the six hundred and sixth compound in the series used by Erlich and Hata in their effort to discover such a combination of arsenic and other chemical substances as would kill the spirochetes without killing the patient.

surely on every germ, wherever located throughout the body. Salvarsan is usually administered by direct injection into the blood, a method that has largely replaced the earlier one of injection into the muscle. Mercury is administered in three ways, by mouth, by inunction and by intermuscular injection. The first method, by mouth, is considered less reliable and more unsatisfactory than either of the other two on account of its effect on the stomach. The only drawback to inunction is that few patients, if they undertake it themselves, have the persistence to carry it out for the length of time required. The method of injection has the advantage of keeping the patient in touch with his doctor, but it has the disadvantage of expense.

Much of the difficulty of a nurse's work is caused by the fact that the symptoms of secondary syphilis yield to treatment so rapidly that the patient cannot be made to realize that all danger and consequently all need for further precaution and treatment is not over. Furthermore, even if untreated, the symptoms tend to disappear of themselves. The first attack, however, is frequently followed by one or more lesser outbreaks occurring at varying periods of time; and these recurrent attacks, often too mild to secure the attention they deserve, are a great source of danger to others, and frequently make even a conscientious syphilitic a menace to the public at large.

The tertiary stage, or what is sometimes called late syphilis, is by far the most serious of all the stages of the disease. It seems to be caused by a few lingering germs that have escaped death with their fellows in the earlier stages, and which may make their attack almost immediately or which may lie quiescent for years, indeed for half a lifetime, before beginning their work. Late syphilis, unlike the earlier stages of the disease, is exceedingly destructive, and the body tissue that is destroyed by the germs is replaced by a poor substitute that does not stand ordinary wear but goes to pieces soon after it grows. Even at this stage treatment is locally effective, but, except within narrow limits, the harm done cannot be repaired. Any part of the body may be attacked—the skin or bones, the blood vessels, the brain and other parts of the nervous system, or any one of the vital organs. Locomotor ataxia and general paralysis are the more familiar forms of late syphilis, but there are many

others, and deaths tabulated under the names of Bright's disease, paralysis and heart disease are many of them undoubtedly due to syphilis or complications of syphilis. In fact, one of the great difficulties in studying the venereal diseases has been their concealment under other names. The All-American Conference on Venereal Diseases held in Washington in 1920 points out the danger of guesswork regarding the prevalence of syphilis. No exact statistics are yet available for the civil population and estimates must therefore be used. In arriving at these, social class and age are such important factors that they must receive careful consideration in any analysis. Dr. Stokes, however, considers an estimate of one man in ten conservative for the United States. He says, "Taking men and women together on the basis of one of the latter to five of the former, and excluding those under fifteen years of age from consideration, this country, with a population of 91,972,266,[4] should be able to muster a very considerable army of 3,842,526 whose influence can give a little appreciated, but very undesirable, degree of hyphenation to our American public health."[5]

Twenty years ago the task of eliminating syphilis would have seemed a hopeless one, but the last twenty years have seen tremendous advances in our knowledge of this disease. Three great landmarks loom up in this advance. The isolation of the germ (the spirochæta pallida[6]) in 1905, the discovery of the Wassermann test in 1904 and the discovery of Salversan in 1910. This means that we know the cause of the disease, that we know how to discover its presence, that we know how to prevent the spread of contagion, and that we know how to cure it if it can be brought under treatment at the right time. We also know far more than we used to know about preventive and educational health work, and we shall be likely to do less groping than in preceding campaigns for the elimination of other diseases.

In some ways syphilis presents a distinctly easier problem than did tuberculosis fifteen years ago. Its germ is more feeble than the tubercle bacillus and is less long-lived under ordinary conditions, and we have a known way of rendering it non-con-

[4] Figures based on 1910 census.

[5] "The Third Great Plague," John H. Stokes, M.D.

[6] Some investigators prefer the term treponema pallidum.

tagious, and what practically amounts to a specific for its cure. Syphilis is also an easier disease to handle from the economic point of view, because the syphilitic patient can as a rule continue work while "getting the cure." Its cause, too, though in some ways presenting peculiarly baffling elements, is on the whole less complicated by the great social maladjustments of poverty and ignorance, with their resultant undernourishment and unwholesome living.

Before discussing the public health nurse's part in the effort to control syphilis, it may be well to review briefly a few of the salient points of gonorrhea, the other important venereal disease, in order that we may then consider them together in their relation to her work.

Gonorrhea is no modern scourge. References to the symptoms and treatment of a disease which would certainly seem to be gonorrhea have been found in an ancient Egyptian papyrus attributed to the year 1350 B.C. Not unnaturally it has often been confused with syphilis because the two have certain points in common, but they are in reality widely different types of disease, owing their origin to different germs, affecting the patient differently, and requiring, therefore, different treatment for their cure. The germ of gonorrhea has not the power possessed by the germ of syphilis to invade every part of the human body, but it sets up an inflammation which, like other inflammations, if not arrested in its acute and active stage, tends to pass into a slowly progressive and chronic stage where it is extremely obstinate and difficult to cure. In men a chronic gonorrhea is bad enough, but in women the pelvic organs frequently become involved, leading to the necessity for serious operations or to a peritonitis that may end fatally. On the whole, gonorrhea is considered more serious for women, while syphilis is more serious for men. It is one of the chief causes of sterility in both men and women, and to its account, as is well known, must be laid a large percentage of the blindness of children.

Unfortunately gonorrhea, unlike syphilis, is not transmissible to animals, a fact that has greatly hindered scientific research; and for gonorrhea there is no specific treatment that either cures it or renders it non-contagious. As long as it lasts it is

a source of contagion to others unless a strict surgical cleanliness is observed.

The average length of the first acute inflammation is about eight to twelve weeks, and it is unnecessary to point out to nurses the importance of early and conscientious treatment at this stage. In addition to local treatment, rest and a careful attention to diet are as necessary as with any other type of acute inflammatory process. It is just here, however, that the patients so often fail to cooperate in effecting a cure. A big city clinic, that has been described by a competent authority as reasonably efficient, has been obliged to admit that more than seventy per cent. of its gonorrheal patients passed through its doors practically unbenefited, the greater number having visited the clinic but once. Treatment usually takes the form of the local use of disinfectants and the administration of certain types of drugs the action of which is prejudicial to the favorable development of the germ.

Because of its persistence in the chronic form, gonorrhea is sometimes credited with the same power of latency possessed to such a remarkable degree by syphilis. But, though a certain degree of latency is possible, authorities are inclined to attribute late subsequent attacks to reinfection rather than to a recurrence of the original disease.

Dr. Stokes calls gonorrhea an obstinate, treacherous and persistent disease, and these traits it shares with syphilis. It is not, however, as clever a disease as syphilis; and though we are less well equipped to fight it, in that we can wave no magic wands like Salvarsan and mercury for its destruction, it can as surely be vanquished if public opinion is once aroused, and individual patients once awakened to the necessity for active cooperation. The presence of the gonococcus can only surely be determined by the microscope, a fact that has long been recognized by the medical profession everywhere. Gonorrhea has one advantage over syphilis from the public health nursing point of view. It causes suffering in its early stages and this tends to bring patients to the doctor or the clinic for relief at a time when they can best be helped.

As with syphilis, no accurate data are available regarding its true prevalence, and statistics must be still further modified by

the fact that gonorrhea being curable, and immunity not being conferred by an attack, one person may have it several times. Gonorrhea also varies greatly with social status, unmarried girls and women of refinement being probably practically free, while figures for the prostitute class run as high as 70 to 95 per cent. Perhaps a conservative estimate for the male population as a whole is 40 to 60 per cent. During the war the percentage for the army was reduced to between 5 and 6 per cent.

Even this short and very inadequate discussion of the various elements that enter into the venereal disease problem must make plain to every nurse the opportunities of the field, whether she enters it as a specialist giving her entire time to it, or as a generalist doing intelligent work as part of a larger health program.

In syphilis we have what has been called the easiest to cure and the most difficult to cure of all the serious diseases; and it is this double characteristic that gives it a peculiar interest from the public health nursing point of view, for it means that we are fighting a foe that has been rendered unnecessarily powerful by public ignorance, and one that can be conquered by public knowledge. In this fight the services of a nurse are needed for many reasons. In the first place, syphilis and gonorrhea are contagious diseases of a type peculiarly difficult to deal with because of their wide prevalence and their intermittent nature. The mild character of earlier attacks, and the power of latency possessed by the germs of both, make a true understanding of their dangers difficult to drive home to the average mind, while their treatment means a degree of patience and persistence on the part of the patient required for the cure of no other diseases. Then there is a stigma attached to these diseases that makes for concealment, and must be removed before really successful warfare can be waged. Individual patients suffer from the effects of this stigma almost more than they suffer from the physical effects of the disease itself, and in addition they suffer acutely from the difficult family and social situations so frequently involved. Also, since they attack the life and sight of children both before birth and in early infancy, they are inexorably bound up with all that broad field of public health nursing that centers around the child. Can any type of work

be imagined offering a finer opportunity for the exercise of training, ability, wisdom and sympathy?

Let us glance for a moment at some of the methods of attack.

It goes without saying that all work is greatly simplified if syphilis and gonorrhea are reportable, like most other contagious diseases. This is the case in the majority of states, but not yet in all. If public opinion is behind compulsory notification the result is statisfactory. If it is not, it only seems to drive to cover, or more literally to quack doctors, patients who would otherwise seek good medical advice. In most states where there are compulsory notification laws, cases are reported by number and not by name, though in some states both methods are used. There is a difference of opinion as to the advisability of seeking early legislation on this point; some students of the subject feeling that without laws carrying with them powers of enforcement it is hardly worth while to try to struggle with the problem at all; others feeling that so much can be accomplished by education, first of the medical profession and then of the laity, that time is saved in the long run by such delay as will give time for this.

All authorities are agreed, however, on the necessity for free clinics that will furnish at least a certain amount of free treatment, and it is also generally agreed that in the majority of places, state or municipal aid must be invoked for their maintenance. Everything about the diagnosis and treatment of the venereal diseases is expensive. Diagnosis and the use of the Wassermann test both imply highly trained and experienced medical men; Salvarsan for syphilis is an extremely expensive drug, and its administration requires skill and knowledge; and in addition, treatment for both diseases must be continued over a very long period of time. It is one of the most painful experiences in a physician's private practice to see the Salvarsan treatment refused on the score of expense by a patient coming to him at the right moment, who without it is a source of dangerous contagion to others, and who must face the sure approach of the secondary stage with a possibility of late syphilis to follow. In a number of states there are laws making treatment, as well as notification, compulsory. This naturally is only possible where free treatment is offered.

Nurses who have worked under both methods say that such laws are pillars of support in the background, but that they are rarely obliged to make actual use of them. The most successful work is undoubtedly done by the nurse who succeeds in developing the highest sense of responsibility in the patients themselves. A patient to whom the whole situation has been carefully explained, and who is constantly encouraged to be persistent and conscientious, will usually listen to reason, though undoubtedly his understanding may be quickened by the knowledge that the law lies behind the counsel he receives.

Where such laws exist the nurse has a right of entry into a patient's home, and the use of this right must be exercised with the utmost tact and wisdom. In many cases far more can be accomplished by means of persuasion at the clinic, while in others a home visit, even if not desired, is the only way to accomplish anything. Though there are some home visits that are made for the avowed purpose only of looking up absentees from the clinic, there are few that cannot be made to fulfil a wider purpose in the hands of a skilful nurse.

It is a mistake to start isolated clinics for venereal disease. They are much better conducted as services of the out-patient department of a general hospital. In this way they are more readily attended by the patients, and no particular line of demarcation is drawn between these and other diseases. A nurse usually does her best work if she is not tied to any one clinic, but is free to follow her patients wherever they go, and to take cases for private doctors whenever she is asked.

The atmosphere of every clinic is made by the doctor and the nurse in attendance, and this atmosphere must be one of friendliness and unfailing dignity. This is of course true of all clinics, but it is especially so of the venereal disease clinic because very varied types of people are thrown together in the waiting rooms, and every care must be taken that the most sensitive patient is not offended. Men and women should be received separately, preferably on different days or evenings, though in one well-run clinic an exception is made to this general rule to allow husbands and wives to attend together, as it is thought that so much is gained by a joint interview with the doctor. In this case the husbands come with their wives on

the women's night, the nurse in charge feeling that if the morale of a clinic is sufficiently high no harm can result from such an arrangement. Every care must be taken to secure privacy for the patients' story, and they must be made on the first visit to feel a degree of kindly personal interest that will encourage them to return, and that will in the end secure regular attendance and obedience to orders.

Most cases of venereal disease are ambulatory, but a certain amount of hospital accommodation is nevertheless necessary. In previous chapters we have spoken of the growing feeling that wards for tuberculosis and mental diseases should be maintained in general hospitals, both for the sake of the patients and because of the educational advantages to doctors and nurses. It is an open secret that every hospital receives many undiagnosed cases of tuberculosis, whatever its policy of restriction may be, and if this is true of tuberculosis, it is equally true of syphilis and gonorrhea. Both of these diseases, with proper precautions, can well be cared for in wards of general hospitals, thus furnishing much needed accommodation for patients, and providing teaching material for the staff. In addition such an arrangement helps to lessen the undesirable isolation in which they otherwise stand.

In venereal disease work, even more than in other types of public health nursing, the first home visit is of importance, and in this initial approach many nurses find the uniform a distinct aid. Such calls take a nurse into a varied field, from the normal, comfortable home to the lodging house and the house of more than doubtful reputation. Every nurse will work out her own method of approach, dependent upon the situation she is encountering, but she must remember that the reason for her call is no one's affair but that of the patient, and she must be careful to respect to the utmost the natural desire for reticence.

Not infrequently her home visiting will take her into houses of ill fame, and here she must resist a temptation to play the part of reformer. It is quite natural that she should want to do so, because her whole training has taught her to try to right what is wrong. She must remember, however, that for her immediate work the most important thing in the world is a freedom of entry that will enable her to find her patients. Any

reform effort which closes the doors of these houses against her, limits her usefulness enormously. Many indirect means will be found by which she can aid the cause of social reform, and in her relationship to individual patients she will often find herself in a position to lend a helping hand at a crucial moment. Nevertheless we must iterate and reiterate that a nurse doing venereal disease work must allow nothing to deflect her from her main purpose, which is the eradication of syphilis and gonorrhea as contagious diseases. For the same reason venereal clinics should not be opened to protective officers, police women and other workers who are in search of some special girl. This rule in no way reflects upon the value of the work they are doing, and it is recognized that often individual girls would be greatly benefited by the possibility thus afforded of bringing them in touch with those anxious and able to help them. The effect on the clinic, however, would be disastrous, for many would stay away if they feared detection, or what they consider interference.

It was early found in tuberculosis work that there was little use in trying to deal with any patient who did not know the nature of his disease and whose family was not also informed about it. This is equally true of the venereal diseases, though it is usually enough that the patient be told and in addition the wife or husband. It is far better that the patients themselves should undertake the difficult task of giving this information, and as a rule they prefer to do so, though after their first interview a nurse often has an opportunity for some of her most important work in giving the right point of view. Aside from the necessity of wife and husband having an intelligent understanding of the situation if a proper prophylaxis is to be carried out, in many cases it will be found that they themselves have already been infected and should be placed under treatment.

In no branch of venereal disease work has more been accomplished than with syphilitic pregnant women. With proper treatment it is possible for a syphilitic mother to have a living and even fairly healthy child, though the children of such mothers must be kept under prolonged observation, probably during all the years of childhood. On account of the danger to the babies' eyes, gonorrheal patients should be confined in a hospital wherever this is possible. If a nurse is doing venereal

disease work as a specialty she may not have the personal care of any prenatal cases. This, however, does not relieve her of the responsibility of doing her best to procure diagnosis, and the right kind of prenatal supervision and treatment for cases where syphilis or gonorrhea may be suspected. Many obstetricians recommend a routine Wassermann test on all pregnant women.

One difficulty of venereal disease work results from a combination of two of its most salient characteristics: first, the fact that treatment to be effective must be continued over long periods of time; and second, that so many of the patients are migratory in their habits. To start a treatment that cannot be completed is poor economy from every point of view. This is so self-evident that the Bureau of Venereal Diseases of the United States Public Health Service caused the passage of a Federal law that made venereal diseases reportable from state to state. It is often, therefore, part of a nurse's duty to give a traveling patient a letter of introduction to present to the health department of the city to which he is going. A statement of his physical condition and the treatment he has already received accompanies the letter. This is particularly valuable for traveling men, marines and others who would otherwise be obliged to forego regular treatment altogether. While a few resent the working of this interstate law, the majority of patients appreciate the opportunity afforded for continued and consecutive treatment.

Many nurses are in some doubt when asked about the danger of contagion from syphilis and gonorrhea under the ordinary conditions of daily life. The germ of syphilis has one good point. Its life is exceedingly feeble except under favorable circumstances. It cannot live at all without moisture, and even with moisture it lives but a few hours in an ordinary environment. Pipes, towels, lip sticks, drinking utensils, etc., used by a syphilitic are dangerous for the immediate use of others; and patients whose work lies in handling food are a source of danger, wherever there is a possibility of moist infected material being transferred to the mouth of other people within the time limit of the life of the germ. The gonococcus can live under rather more adverse circumstances, but it, too, requires moisture for its existence. Unlike the germ of syphilis it rarely if ever attacks the mucous

membrane of the mouth, but on the other hand it has a special predilection for that of the eye. The same asepsis is required in its care as for any other highly contagious disease in which contact infection is a factor.

The question of the safety of marriage for the syphilitic constantly arises. Dr. Stokes says that if a patient is effectually treated with Salvarsan and mercury over a period of three years, and if he has remained free from the disease after the treatment has stopped, having had repeated negative Wassermann tests of blood and spinal fluid, he may marry in five years from the beginning of his infection. This is called the five year rule and is considered conservative, steering a middle course between a too great optimism and a pessimism that would deny the syphilitic all hope of the happiness of family life. The abortive cure usually requires about a year.

There is much in common between the venereal disease campaign and the campaigns against tuberculosis and mental disease. In all three it has been necessary to wage warfare not only against the diseases themselves, but against a public prejudice and ignorance that have for years fostered silence and concealment concerning them. With tuberculosis, knowledge and a changed point of view are having a sure effect, and tuberculosis as we have known it in the past is already doomed. A like fate undoubtedly awaits the venereal diseases but much vigorous work will be required first. Nursing has a wonderful tradition that has come down to it through the ages, that wherever human suffering exists there it is a nurse's privilege to be. Perhaps that privilege can be no better exercised than in ministering to a class of patients whose physical suffering is augmented by the fact that a stigma is attached to the disease which has attacked them. By this ministry a nurse may gain a personal understanding that will perhaps help her to do her part in bringing the venereal diseases out of their present hiding places into the full light of day, where they may be fought and vanquished as have so many other scourges of mankind.

PART VI

RECORDS AND STATISTICS

Chapter 1

RECORDS AND STATISTICS

Recognition of the importance of record-keeping in the field of public health nursing has been a comparatively late development. Twenty, even fifteen years ago, visiting nurse associations prided themselves on their economy in this matter; and only a few of the more enlightened kept anything but the simplest form of record, a mere identification card being as a rule considered amply sufficient. A different attitude toward the question has come as a natural sequence to the growth of the movement, and to a changed conception of the duties and responsibilities of a public health nurse.

The early nurses worked very individually and very locally. They gave bedside care to their patients and taught the principles of hygiene in the homes, but they were not expected to concern themselves with the causes of the conditions that they found; nor were they particularly interested, as a group, in the relationship of their local work to the health movement as a whole. It was impossible, however, that intelligent nurses and intelligent boards of managers should long continue to work in this way. Some among them were not content with alleviative measures alone, and the first utterance of questions regarding the necessity of existing health and social conditions opened the door for a new type of work, in which the tabulation of accurate information was destined to play an important part. In the early days, too, there was little cooperation between agencies. Many nurses administered small relief funds, doing for their patients themselves much that is now done for them by others. As cooperation increased, information in an available form became more necessary than in the days when a nurse played a lone hand, and carried all of her patient's affairs "in her head." In addition to these changes the increase in the number of cases carried, and the consequent enlargement of the

staff, has made necessary for the larger organizations a type of supervision hitherto unknown, and one demanding for its operation new methods of record-keeping.

As the place therefore of public health nursing, both in local and national health programs, became more clearly defined; as cooperation with other agencies developed; as the volume of work everywhere increased, and with it the size of the staff required for its performance; and as the value of health studies became gradually recognized, we have come to a new point of view in regard to records and statistics; and they no longer take their place as a comparatively unimportant adjunct to the care of the sick, but are considered vital to the proper administration of all public health nursing work.

Records are kept for two purposes: first, as a form of indispensable bookkeeping which will enable those managing the work to know whether or not an organization is being run on good business principles, and whether it is fulfilling the purpose for which it is intended; and second, as a means of gathering data which will give accurate information concerning the conduct of individual cases, and from which studies may be made of the broader aspects of the question of illness and health as applied to the community and to the country at large.

Dr. Goldstein tells the story of a man who was started in business by the present of a sum of money with which he bought oranges at a dollar a hundred. He sold them at a cent apiece and was amazed when all were gone to find that he had made no profit. An extreme example of lack of bookkeeping, perhaps, but it is not without its parallel in the experience of more enlightened individuals than this unfortunate vender of oranges.

The funds of almost all public health nursing organizations are carefully and conscientiously administered, the accounts properly audited, trust funds wisely invested, and books kept in an orderly and business-like way. How many organizations, however, have worked out a satisfactory method of ascertaining the exact cost of each visit, or the price of administration of the different departments of work in which they are engaged? Surely no type of business enterprise more urgently requires a good system of bookkeeping, if it is to be intelligently administered, than one that sells its commodity on a sliding scale, and

also gives it away without recompense. The trouble usually lies in the fact that no one is sufficiently interested in using the treasurer's figures in their relation to the work done.

A few simple facts should be known by every organization. A treasurer's report gives information as to the sources of income. It shows the amount of money expended for overhead expenses, for rent, telephone, office equipment, etc., for salaries, for transportation, for supplies, for sending delegates to conventions, and for any special or unusual activities carried on. The director's report gives the number of nurses, the number of patients, the number of visits, and a more or less full statistical statement as to the type and disposition of the cases. In how many organizations, however, are these reports studied for the purpose of drawing an analogy between the two? Even the fundamental principle, that time that is paid for represents money, does not always seem to be clearly understood. Nurses' meetings, for instance, are highly desirable and necessary, but very few organizations have taken the trouble to figure out how much they cost. If sixteen nurses attend a meeting lasting an hour, and require another hour for travel to and fro, it is quite evident that thirty-two hours of the time of the staff has been spent, and this represents the working day of four nurses. If these meetings are held regularly, the annual cost can easily be computed. If nurses are present at clinics or conferences, the cost of such attendance should be known. It is important also to know the amount of time spent by nurses between cases. Sometimes a somewhat more expensive mode of transportation will prove an economy. Some types of work are so expensive, if reckoned on the visit basis alone, that a wholly erroneous conception of the cost of the nursing service as a whole will be gained, unless the various departments are tabulated separately. These few instances of the cause of vagueness regarding the business situation may be supplemented by the experience of any public health nursing organization.

To the inexperienced the complexity of the salary question is a source of much confusion in estimating cost. A sliding scale is quite universal, and changes in the staff, whereby nurses are advanced to higher salaries and older nurses are replaced by new nurses at lower salaries, necessitates a constant readjust-

ment of the pay roll. All these complications, however, present no insuperable difficulty to the trained accountant or statistician, and money will be well spent in paying for the services of an expert, who in a few hours can devise a method of bookkeeping that will probably surprise by its simplicity those unversed in such matters.

Every organization strives for economy, but many try to attain it in the wrong way, mainly because their system of record-keeping does not give them the essential facts. In an effort to keep down expenses insufficient office room is rented, one telephone line is installed instead of two, messenger service is reduced, salaries are not raised to meet the increased cost of living, and general discomfort prevails. What is the result? The nurses are not suitably accommodated in the office, so time is lost. They must wait to use the telephone, so time is lost. They are called upon to go a little out of their way to do an errand that might be done by a messenger boy, so time is lost. They live uncomfortably because board has become higher, and in consequence do not feel as energetic as formerly, so time is lost. The same thing obtains with the office force. Money is saved in janitor service or the wages of a cleaning woman, so a supervising nurse, drawing a salary of eighteen hundred dollars a year, cleans the shelves in what she calls her spare moments, while a stenographer spends her hundred-dollar-a-month time in assisting her. There is no extension telephone on the stenographer's desk, so, perhaps fifty times a day, she leaves her work to answer a call. The salary of an office assistant is saved, but filing, copying, etc., are done at what is really an exorbitant price for such work.

Let the director of an organization so managed take pen and paper in hand and add the additional annual expense of suitable office quarters, an adequate telephone service, a free use of messenger boys, the wages of women to clean, and clerks to do ordinary office work. Let her then add the expense of the unnecessary loss of time of each nurse and office employee and she will find herself in possession of some illuminating figures to present to her board. A salary suitable for the expert work of a well-trained nurse is absurd if paid for the cleaning of shelves or the running of errands, and it is a still greater waste

when it is paid for time spent in unnecessary waiting to use a telephone or other office convenience. It is easy to be penny-wise, but it requires intelligence and a good system of record-keeping to avoid pound foolishness.

There is one fundamental question to which every public health nursing organization should insist upon having a satisfactory answer through its record system—namely, is the organization performing the function for which it exists? As most nursing organizations exist for a very broad and far-reaching purpose, this question can only be answered by a knowledge derived from a good system of records. An organization expects as a rule to reach an entire community. Is it doing so? It has been estimated from a series of sickness surveys made by Dr. Frankel and Dr. Dublin of the Metropolitan Life Insurance Company that the number of persons seriously sick in a community in any month is approximately three per cent. of the population. An organization should be in a position to know exactly how many of this number it is reaching. Furthermore, it is not enough to know that a fair proportion of the sick are being cared for; it is important to know who they are. Is there a proper geographical distribution of the nurses' services? Are they caring for men, women and children in satisfactory proportions? And how about the colored population and the foreign element? In addition to these questions, it is important to know how the nurses' time is being spent from the point of view of the diseases nursed and the type of patient instructed. Is the maternity service being developed at the expense of the acute cases? Are an undue number of chronic cases being carried, for whom better provision could be made? On the answers to such questions as these should depend the annual program of every well-run organization.

Public health nursing has by no means passed out of the experimental stage of its development, but of what value is an experiment the results of which are only guessed at? There is nowhere an unlimited amount of money for the work, therefore it behooves every organization to calculate closely and to buy only what is truly worth having. If it should be proved that babies do as well without the so-called fifth week visit and that mothers do much better if additional time is spent upon them

before the baby's birth, it is far wiser to spend money for the latter instead of for the former, if there is not enough for both.

A record system has another and very important use. Modern supervision is impossible without it, for unless a supervisor can follow the cases through the nurses' records, she can neither give wise advice regarding their conduct, nor can she furnish educative supervision to the nurses placed under her. She will also be unable properly to evaluate the work done in the territory for which she is responsible, and her contribution in constructive thought to her organization will consequently be reduced.

There are few organizations that are not now more or less convinced of the importance of record-keeping, but with the constantly increasing demand made upon the nurses' time, it is not an easy matter to arrange for it. The whole question is one of proportionate expenditure. No organization attempts to do its work without records. Some have highly developed statistical departments in charge of expert registrars who so tabulate the data that they serve not only for purposes of administration and self-examination, but are available for more general health studies. Others have reduced the time spent on records to the minimum compatible with safety, and no tabulation is done beyond a mere count which shows the number of cases admitted, discharged and carried over. Between these two extremes will be found every degree of completeness of record.[1] Each organization must work out its own salvation in this respect, and must

[1] The Committee on Records and Statistics of the National Organization for Public Health Nursing has put into circulation two record forms. The committee recommends as a minimum that information covering the ten following points be obtained by every nurse doing public health nursing:

1. Sex (male or female).
2. Marital relation (single, married, widowed).
3. Race (white or colored).
4. Age.
5. Place of birth.
6. Nationality of father, of mother.
7. Occupation.
8. Diagnosis.
9. Number of visits.
10. Condition on discharge.

determine for itself the proportion of time and money to be spent on its record system. In arriving at a conclusion, however, the expense of ignorance must not be forgotten. If time is being spent on unproductive effort, a little more time spent in discovering the fact will prove true economy.

Dr. Dublin suggests for an organization doing general work a set of six forms for the use of the staff, with five summarization tables.[2] The forms include a call slip to record the original call for service, an assignment slip for assignment of the day's work for each nurse, a relief work slip to be used for the arrangement of work when the regular nurse of a district is off duty, a new case history slip, a final history slip with space on the reverse side for a record of visits, and a bedside notes slip to be left at the patient's home.

The information is tabulated monthly by means of tables. The *first* table gives a complete monthly summary of the organization's work, so arranged as to be daily kept up to date. From it can be learned the number of old and new cases, the total number of visits, the number of staff nurses, supervisors and clerical workers on duty, and the type of work done by them (field, office, clinic, etc.). This table is also arranged for monthly and annual comparisons of the number of cases, the number of visits, and the number of hours of duty. The *second* table summarizes the monthly work of each nurse, giving the cases seen, the visits made, the days on duty, and how spent (field, office, clinic), with the time given to vacations or sick leave. Table *three* summarizes the diseases according to sex, color and age groups, and also gives percentages. Thirty-five principal diseases are listed according to the International List of Causes of Sickness and Death. These thirty-five diseases usually account for seventy-five or eighty per cent. of the cases. Others are grouped and listed under "other diseases and conditions." Table *four* shows, in addition to the number of cases of each disease, the number of visits and nursing days spent upon them. Table *five* gives the condition on discharge of the cases closed during the month, and the place of transfer, tabulated according

[2] "Records of Public Health Nursing," five lectures delivered before the Department of Teaching and Health, Teachers College, Columbia University, April, 1921, reprint from *Public Health Nurse.*

to disease. These forms will not necessarily fill the need of every organization, but they have been described because the information that may be obtained from them is for the most part desirable everywhere.

Tabulation by a simple process of sorting is not difficult.

For special types of cases special information will be required. Tuberculosis records will give information as to the patient's probable source of infection, whether he is careful or a menace to the community, the number of other tuberculosis people in his family, etc. Child welfare cards will give space to weight, methods of feeding and other special points affecting child life, and maternity cards will give appropriate data regarding previous confinements and special physical conditions. Mental hygiene cards will be informative on the heredity of the patient and on conditions affecting his nervous health. School cards will be so arranged as to follow the child from grade to grade, giving a picture of his physical progress. Industrial cards will require space for special information regarding industrial conditions.

It is a good rule that no record should be filed until it is complete and strictly accurate in every detail. This will necessitate a certain amount of editing, which will be found easier if done immediately. Back history is difficult, and often expensive to obtain.

An annual report should contain the results of the year's record and bookkeeping, yet how few organizations make the most of their annual reports, though the opportunity offered by their publication is far too valuable to be thus neglected. An annual report should be compiled with a view to interesting and informing four groups of readers,—the board of managers, the staff, the local community, and that wider public throughout the country interested in public health nursing. To accomplish this purpose it should contain, a clear and business-like report from the treasurer, with an estimated budget for the coming year; carefully tabulated statistics interestingly interpreted; a narrative account of the year's accomplishment with enlightening comment on the causes of success and failure; a description of all proposed developments; and a plain statement of the general policy of the organization.

One of the most important uses of the annual report, that of furnishing material for comparative study, is at present rendered practically negligible because methods of issuing statistical and financial statements differ so widely throughout the country. When a public health nursing organization has succeeded in working out a good individual system of record and bookkeeping, it has attained only an individual success. A clear insight into the business principles of public health nursing administration will never be possible until some comparative study of the financial reports of other organizations can be made. At present any effort to study different annual reports with a view to gaining helpful information regarding relative expenditure is a sadly disappointing task, and the same is equally true in regard to the record of other important data.[3]

The question of economy of time in the matter of record-keeping is everywhere important. Two general principles may be accepted: well-arranged printed blanks save time and therefore money, and trained clerical workers produce a like result. If no clerical work is required of the nurses except that which cannot possibly be done by others, an actual saving in money will be effected; though this truth is sometimes obscured by the fact that the payment of salaries for office assistance shows very plainly on the account books, while the time stolen from the nurses' daily nursing work is not so clearly set forth. Even the single nurse working alone will do well to secure voluntary assistance for her clerical work whenever possible.

There will always, however, be a certain amount of record-keeping that can be done by the nurse alone. Many advise that all history cards should be made out at the patient's home, because of the greater accuracy secured and the time saved. For other record work a regular time should be assigned and strictly kept for this purpose. Only in this way can accuracy and promptness be insisted upon. Nurses do not always realize the loss of time caused by inaccuracy, but there is no reason why such costly carelessness should be more leniently judged than are mistakes in other branches of the work. Most nurses

[3] A committee to study visiting nursing, appointed by the National Organization for Public Health Nursing, is now at work. Its report will deal with this subject.

who thus waste the organization's time do so quite thoughtlessly. Their cheerful explanation that they have no head for figures is not, when analyzed, very satisfactory; for as a rule the mistakes are not due to mathematical incompetence, but to a carelessness that they do not dream of displaying in the exercise of their nursing duties. Probably the reason why many staff nurses dislike, and undervalue this part of their work is because no one has tried to interest them in it. It is dull work to record facts if one hears nothing of the deductions to be drawn from them, but comparative statistics can be made vitally interesting if well set forth, and few nurses will fail to respond to a stimulus of this sort.

If all public health nurses could be made to realize the importance and value of their work of record-keeping; if they would bring to it the same spirit of service, and the same interest in detail, that they bring to the care of the patient; if they could go a step farther and for one moment visualize the hour spent at their desk in its relation to the whole broad field of public health nursing;—there would be less impatience and more interest in this part of their work.

The laboratory worker has changed the course of thought, and therefore of action, toward many diseases and their treatment; and through his labors, has affected the lives of thousands of men and women whom he has never seen. He would, however, have accomplished little if he had been content to make his experiments without recording their success or failure. The active nurse, working with the stimulus and incentive of personal service, has a lesson to learn from these unseen workers upon whose painstaking and impersonal labors the whole structure of her own work is built.

She, too, is making important discoveries which sometime may be used to increase the welfare of the human race in ways she does not dream of. Her written records, quite as much as the individual care of her patients, are likely to be a means to this end; so she may well dignify her task of record-keeping with a consciousness of its importance and value, bringing to it the same enthusiasm, and the same whole-hearted gift of service, that she is so ready to lavish in other ways, and that constitute the very essence of public health nursing. Nor is it enough for

the staff of an organization to appreciate the value of its records and statistics. Their importance should also be realized by every board of managers. Through them the whole community may be induced to take an intelligent interest in the results of the work of the organization that it supports.

APPENDIX

Chronology

In writing or speaking on public health nursing subjects a few important dates are constantly required. The following list chronologically arranged contains those which stand out as marking the development of the movement. Absolute accuracy has been difficult because of frequent difference of statement by those whose authority carries equal weight. Work tentatively started under informal conditions is in most instances the cause of confusion; the date of formal inauguration being given in some accounts of the enterprise, the date of the earlier experimental effort in others. Under such circumstances the generally accepted date has been selected.

1050 A.D.	Hospital of St. John the Almoner established at Jerusalem from which grew the Fraternities of the Knights Hospitalers of St. John of Jerusalem, of Malta and of Rhodes.
1182–1226	St. Francis of Assisi.
1207–1231	St. Elizabeth of Hungary.
1347–1380	St. Catherine of Siena.
1611–1615	Visiting Nursing done by the Order of the Visitation of Mary.
1638	Society of St. Vincent de Paul founded.
From latter part of 17th Century to middle of 19th Century	So-called dark period of nursing.
1798	New York Hospital inaugurated a system of regular instruction for nurses.
1813	Ladies' Benevolent Society of Charleston, S. C., founded.
1820–1910	Florence Nightingale.
1836	Pastor Fliedner created Modern Order of Lutheran Deaconesses at Kaiserswerth.
1840	Establishment of Nursing Sisters of Devonshire Square, London.

1848	The Society of St. John's House founded in London.
1859	The first District Nursing Association established in Liverpool by William Rathbone.
1860	Nightingale Training School for Nurses established at St. Thomas' Hospital, London.
1864	Treaty of Geneva. Inauguration of the Red Cross.
1868	The East London Nursing Association established.
1872 (Sept. 1)	Training School for Nurses established at New England Hospital for Women and Children.
1873 (May 1)	Training School for nurses established at Bellevue Hospital, New York.
1873	Training School for Nurses established at New Haven Hospital.
1873 (Nov. 1)	Training School for Nurses established at Massachusetts General Hospital.
1874	The National Nursing Association inaugurated in London by the Order of St. John of Jerusalem.
1874	School Medical Inspection first established in Brussels, Belgium.
1875	The Metropolitan and National Nursing Association founded in England.
1877	Woman's Branch of the New York City Mission first organization in America to send trained nurses into the homes of the sick poor.
1879	New York Ethical Society placed trained nurses in dispensaries.
1881	American Red Cross established as a permanent Society.
1881	First Canadian Training School established Toronto General Hospital.
1886	Boston Instructive District Nursing Association established.
1886	The Visiting Nurse Society of Philadelphia established.
1887	Queen Victoria's Jubilee Institute for Nurses founded in England.
1889	Chicago Visiting Nurse Association established.
1892	School nursing first undertaken in London.
1893	Henry Street Settlement founded.
1893	The Society of Superintendents of Training Schools founded (now the League for Nursing Education).
1894	School Medical Inspection inaugurated in Boston.
1895	The Lady Almoner introduced into English Hospitals.
1896	The Nurses' Associated Alumnæ founded (now American Nurses' Association).

1897	Victorian Order established in Canada.
1898	First municipal nurse employed in America at Los Angeles.
1898	London School Nurses' Society established.
1899	Hospital Economics Course established at Teachers College, Columbia University. Afterward Department of Nursing and Health.
1900	The *American Journal of Nursing* first published.
1901	58 organizations doing public health nursing. About 130 nurses. (Statistics presented by Harriet Fulmer at International Congress of Nurses in Buffalo.)
1905	200 organizations. About 440 nurses. (Statistics presented by Ysabella G. Waters at International Conference of Charities and Corrections.)
1909	566 organizations. 1,413 nurses. (Statistics gathered by Ysabella G. Waters.)
1916	1922 organization. 5,152 nurses. (Statistical Department, National Organization for Public Health Nursing.)
1922	4,040 organizations. 11,548 nurses. (Statistical Department, National Organization for Public Health Nursing.)
1902	"Midwives' act" passed in England.
1902	School nursing started in New York.
1903	Tuberculosis nursing first undertaken as a special branch of nursing.
1904	School nursing taken over by London County Council.
1905	First industrial nurse employed by Vermont Marble Works.
1905	Medical Social Service Department established at the Massachusetts General Hospital.
1905	American Red Cross re-organized and re-incorporated.
1905	National Association for the Study and Prevention of Tuberculosis founded.
1906	First postgraduate course in District Nursing offered by the Instructive District Nursing Association, Boston.
1908	First Mental Hygiene Committee organized in Connecticut.
1909	*The Visiting Nurse Quarterly* first published. (Now the *Public Health Nurse.*)
1909	American Association for the Study and Prevention of Infant Mortality founded.
1909	National Committee for Mental Hygiene formed.
1909	The Metropolitan Life Insurance Company first offered home nursing to its industrial policy holders.

1909	Jubilee Congress of District Nurses held in Liverpool.
1910	The course in Public Health Nursing established at Teachers College, Columbia University.
1911	First State public health nursing laws enacted.
1912	The National Organization for Public Health Nursing founded.
	1913 First Annual Meeting, Atlantic City.
	1914 Second Annual Meeting, St. Louis.
	1915 Third Annual Meeting, San Francisco.
	1916 Fourth Annual Meeting, New Orleans.
	1917 Fifth Annual Meeting, Philadelphia.
	1918 Sixth Annual Meeting, Cleveland.
	1920 First Biennial Meeting, Atlanta.
	1922 Second Biennial Meeting, Seattle.
1912	Rural Nursing Service of the American Red Cross established. (Later Town and Country Nursing Service.)
1912	Federal Children's Bureau established.
1918	Name of Town and Country Nursing Service of the Red Cross changed to Public Health Nursing Bureau.
1918	Nursing committees of the Council of National Defense appointed. General Director of the National Organization for Public Health Nursing acting as secretary. Headquarters Washington.
1918	Cantonment Zone work established.
1919	English Ministry of Health established.
1919	Child Health Organization founded.
1920	International course in public health nursing established in London by League of Red Cross Societies, at Kings College. Later removed to Bedford College.
1920	National Health Council established.
1921	National Organization for Public Health Nursing moved headquarters to 370 Seventh Avenue, where it is housed with other national health agencies.
1922	Amalgamation of the American Child Hygiene Association and the American Child Health Organization under the name of the American Child Health Association.

National Organization for Public Health Nursing

The National Organization for Public Health Nursing came into existence to fill a very obvious need.

All over the United States public health nurses were being employed by industrial concerns, by small clubs, by churches,

by municipal and state bodies, and by other agencies whose primary function was not nursing work; as well as by visiting nurse associations, tuberculosis leagues and child welfare societies existing for the purpose of health propaganda.

Though most of these organizations and agencies were earnestly endeavoring to do good and conscientious work, the only definite standards set were those of the larger organizations, whose methods and ideals might or might not be known to those newly engaged in the work.

Borne on the tide of a general public interest the public health nurse was everywhere demonstrating her value, but the thoughtful saw in the very force of this tide a danger, unless the highest professional and ethical standards could be set and maintained.

In order to secure such standardization a joint committee was appointed in 1911 by the American Nurses' Association and the Society of Superintendents of Training Schools (now the League for Nursing Education). The members of the Joint Committee were:

Lillian D. Wald, Chairman
Anna W. Kerr
Jane A. Delano
Ella Phillips Crandall
Mary Beard
Mary S. Gardner

This Committee sent out to the 1,092 agencies then known to be engaged in public health nursing, letters setting forth the dangers of unstandardized work; and asked that delegates be sent to the annual meetings of the two national nurses' organizations (the American Nurses' Association and the Society of Superintendents) to be held that year in Chicago.

The response was encouragingly enthusiastic and in June, 1912, the National Organization for Public Health Nursing came into existence with Lillian D. Wald as its first president. Briefly, the object of the Organization was the stimulation and standardization of public health nursing, and furtherance of cooperation between those interested in public health nursing measures. Like the League of Nursing Education, the new Organization was closely affiliated with the American Nurses' Association through provision for the ex-officio membership of its President on the

directorate of the Association, and also through a provision for joint annual meetings of the three boards.

Membership in the National Organization for Public Health Nursing is of several types, allowing for nurse, lay and corporate representation. Nurse membership is conferred only on nurses possessing specified professional equipment; and corporate membership, only on organizations employing nurses, a given percentage of whom are eligible for nurse membership. In this way, a high educational standard is maintained; while at the same time, associate nurse and associate corporate membership provide that all agencies and all nurses engaged in public health nursing are entitled to the services of the Organization, even though fundamental educational preparation may not meet the requirements for corporate or nurse membership with full voting privileges.

The possibilities of usefulness opened to the Organization have far exceeded the expectations of the founders. It soon became evident that the bringing together of scattered organizations and the coordination and standardizations of methods was to be a part only of its activities. Very definite creative work lay before it.

During the first year an executive secretary was engaged and headquarters secured in New York. Ella Phillips Crandall, a member of the original committee, accepted the position. She was succeeded in 1920 by Florence M. Patterson who served for two years, and was succeeded in 1922 by Anne A. Stevens. At the end of the first year Miss Wald resigned the Presidency and became honorary President. The succeeding Presidents have been Mary S. Gardner, Mary Beard, Edna L. Foley, Katherine Tucker (acting President) and Elizabeth G. Fox.

With the establishment of the National Health Council in 1920, the National Organization for Public Health Nursing took its place as one of twelve original members; and in the same year, became one of the group of national health agencies to establish headquarters in the Penn Terminal Building at 370 Seventh Avenue, New York.

The organization offers the following services through its various departments.[1]

[1] Statement written by Miss Anne A. Stevens, January, 1924.

I. Through its Vocational Department.
   1. Attempts to fit the "right nurse to the right work" by
      a. Suggesting to inquiring employers available nurses whose credentials indicate their fitness for the work to be done.
      b. Informing nurses who have registered with the department of the positions open for which their credentials indicate their fitness.
   2. Helps to develop uniformity in public health nursing by
      a. Calling to the attention of organizations such points in their administration as differ from prevailing standards.
      b. Helping individual nurses to make arrangements for the training or experience necessary to prepare them for the type of work they most desire to do.

II. Through the Division of Nursing of the American Child Health Association.[2]

Offers to nurses and organizations engaged in child health nursing the services of specialists in that field. These specialists to study the work being done, giving publicity to the best methods discovered, and assisting by means of correspondence, consultation and the visits of a field secretary those who request help in the solution of specific problems.

III. Through its Field Service.
   1. Offers the services of the Field Secretary to state organizations desiring such assistance
      a. In explaining the amendment to the By-laws providing for branches, or
      b. In developing state affiliation as a branch of the National Organization for Public Health Nursing, or
      c. In helping with its particular problem of state organization.
   2. Offers the services of the staff members to communities and organizations desiring help in the solution of their particular problems.
   3. Offers help with programs for meetings when requests for a speaker can be met by the members of the staff.

      (This service is dependent upon a careful consideration of all requests and the ability to arrange an itinerary which can meet them.)

[2] The American Child Health Association, instead of establishing a separate nursing service, requested the National Organization for Public Health Nursing to act as its Division of Nursing.

IV. Through the National Health Library (of which the National Organization for Public Health Nursing Library Department is a part).

1. Offers bibliographies and reading lists, prepared periodically on subjects of general interest to public health nurses, and special bibliographies and reading lists on any health subjects, as requested.
2. Offers loan package libraries of current pamphlets on health subjects to nurses, students, club women, and general field workers.
3. Offers reading material on health subjects through Library Centers developed in cooperation with State Libraries.
4. Offers advice regarding health literature suitable for public libraries, to nurses and librarians interested in providing such reading for their communities.

V. Through the Educational Department.

Offers the services of its Educational Secretary to assist in the study and solution of problems connected with the education of nurses for public health nursing.

VI. Through the Eligibility Department.

1. Assures to communities the best kind of public health nursing service by
   a. Upholding the fundamental technical training for nurses by giving specific help and advice as to supplementary training, when the fundamental training of any individual nurse has been less than the minimum.
   b. Assisting the National League of Nursing Education to maintain standards of nursing education.
2. Offers a depository for credentials.
3. Offers information about the content of courses given in past years by a large number of the nurse training schools, domestic and foreign.
4. Offers to all organizations employing nurses and becoming corporate members of the National Organization for Public Health Nursing an annual personnel rating. In this way employers of nurses may be informed of the standing of their nursing staffs in relation to the standard for fundamental technical training, accepted by the three national nursing associations as a requirement for membership in the National Organization for Public Health Nursing.

VIII. Through its Membership and Publicity Department.

1. Offers the use of carefully prepared publicity material to nurses who wish to interpret public health nursing and

the work of the National Organization, to the general public and prospective members.

2. Offers to local organizations and individual nurses, specific suggestions as to the methods and types of material that may be used in their local publicity campaigns.

IX. Through the publication of a monthly magazine.

Offers to every member, and to others interested in public health nursing, a medium for the exchange of information and the discussion of problems related to public health nursing.

X. Through the work of committees and sections.

Offers a consensus of opinion from qualified groups on specific questions of public health nursing.

XI. Through the New York Office.

1. Offers help by letter or personal interview in the solution of problems presented by communities, organizations and individuals.
2. Offers for sale reprints of magazine articles, pamphlets and publicity material of value in public health nursing.

The following standing committees serve the Organization, the names being self-explanatory:

Committee on Education.
Committee on Membership.
Publications Committee.
Committee on Finance.
Eligibility Committee.
Vocational Committee.

There are four Sections of the Organization in which membership is open to any nurse member:

Child Welfare Nursing Section.
School Nursing Section.
Tuberculosis Nursing Section.
Industrial Nursing Section.

Section meetings provide opportunity for those interested in that particular phase of public health nursing, to consider their common problems and to make such recommendations to the board of directors of the Organization as may seem desirable. Special committees of the section may also be appointed to study and report upon selected subjects.

Provision is made for state affiliation with the National

Organization for Public Health Nursing through its state branches. These have national representation through their presidents who become ex-officio members of the board of directors.

To many thoughtful nurses the National Organization for Public Health Nursing stands as a bulwark of strength in these rather troublous times; and it is undoubtedly true that countless nurses who give to it little thought profit more than they will ever realize by its mere existence, just as they profit by the fire and police departments that guard them from dangers which they rarely consider.

Red Cross Public Health Nursing Service

The rural nursing service of the American Red Cross was inaugurated in 1912. This was made possible by a gift of $100,000 from Jacob H. Schiff, given at the suggestion of Miss Lillian D. Wald, and later supplemented by other gifts. At the time of the establishment of this service public health nursing, though well advanced in cities and in the larger towns, had made but little headway in rural districts. The new service was placed under the department of nursing, of which it later became a bureau and where it remained until the Red Cross abandoned the departmental form of organization in 1921.

It was not the purpose of the service to assume from headquarters financial responsibility for local nursing work, but rather to stimulate local responsibility to the point of support, and to supply qualified nurses on request, afterward furnishing supervision and advice.

From the first only well-prepared nurses were selected and every effort was made to maintain a high standard of efficiency. To secure this it early became necessary to furnish scholarships to nurses for postgraduate training in public health nursing. Such scholarships are still offered, and have proved of great value in furthering the cause of public health nursing throughout the country.

At the end of the first year the name of the Rural Nursing Service was changed to Town and Country Nursing Service, a name more truly descriptive of the work done.

Though the National Organization for Public Health Nursing

was also established in 1912, the service offered by these two national bodies differed fundamentally from each other. The Town and Country Nursing Service of the Red Cross was distinctly administrative in character, while the National Organization for Public Health Nursing was at that time, and has always remained, a non-administrative body.

At the beginning of the war the service was well established, though the number of nurses was small. There were about one hundred scattered through the country, working under a variety of affiliated groups, such as visiting nurse associations, county bodies, health leagues, women's civic clubs, business corporation and, in a few instances, Red Cross chapters; though the latter form of organization was far less developed than at a later period. With the tremendous war development of the Red Cross, the Town and Country Nursing Service, after a brief period of instability, gained new impetus and with its name changed to the Bureau of Public Health Nursing entered a new phase of usefulness. In addition to the rural work, the bureau acted as a recruiting agent for the United States Public Health Service in securing nurses for work in the extra-cantonment zones.

In common with the other bureaus and departments the Bureau of Public Health Nursing shared in the general Red Cross scheme of decentralization, the division offices taking over much of the work formerly administered from Washington.

At the signing of the armistice the bureau began a period of rapid and wide-spread development. The chapters, with money in hand and a well-developed organization, everywhere evinced a natural desire to turn to good account the enthusiasm and interest of their members for local benefit, and within a few months calls for nurses came from all parts of the country until the demand was far in excess of the supply.

The early nurses of the Town and Country Nursing Service worked in small communities covering only prescribed areas. As the work grew, their field of service was extended; and after the war, owing to the assumption of responsibility by the chapters, the county became a common unit of activity. In many instances, too, the Red Cross entered into affiliation with the National Tuberculosis Association and the state departments of health, to place supervising nurses in the various states to work,

when possible, in connection with existing state bureaus of public health nursing. Such arrangements were, however, considered temporary, looking toward a time when the state itself should assume full responsibility; and more recent arrangements provide for special state supervisors for the Red Cross work.

The general reorganization of the Red Cross which took place in 1921 brought about a closer relation between the general field staff and the nursing field staff, and also somewhat changed the status of the Bureau of Public Health Nursing. With the elimination of the departmental form of organization the bureau assumed the name of the Public Health Nursing Service, and its director became a member of the National Staff Council. It continues, however, to be closely allied to the Nursing Service, though its director is directly responsible to the Vice Chairman of the Red Cross. Its administrative character was also changed to an advisory one.

Responsibility for foreign public health nursing work, with the exception of our insular possessions, has never been assumed by the public health nursing service; but has remained with the nursing department, largely because all foreign public health work has been so interwoven with other nursing activities that disassociation seemed undesirable.

At present there are over 1,000 Red Cross public health nurses in the United States, a corps of women of whom any organization might well be proud, doing a work that is having its effect on health conditions all over the country.

National Health Council[3]

In order to bring about a better coordination of the activities of national official and voluntary health agencies, the National Health Council was created in January, 1921. *Direct members of the Council are:* American Child Health Association; American Public Health Association; American Red Cross; American Social Hygiene Association; American Society for the Control of Cancer; Conference of State and Provincial Health Authorities of North America; National Committee for Mental Hygiene; National Organization for Public Health Nursing; National Tuber-

[3] Statement by James A. Tobey, Administrative Secretary of the National Health Council.

culosis Association. *Associate members include:* American Association of Industrial Physicians and Surgeons; National Committee for the Prevention of Blindness; Women's Foundation for Health. *The Conference members are:* United States Children's Bureau; United States Public Health Service. Offices are maintained in New York (370 Seventh Avenue) and Washington. Eight of the organizations forming the Council have their headquarters at 370 Seventh Avenue, as do also a dozen other health agencies; and many common services are undertaken, such as joint library, accounting, shipping, telephone and other mechanical duties. The Council also has many interstaff committees, such as publicity, statistics, health films, and health examinations. A programs- and budgets-committee analyzes the plans and finances of each organization in order to work out methods for eliminating duplication. An Information Service is maintained, and reports on national health legislation are issued when Congress is in session. A Monthly Digest is issued, and the Council has also arranged for the publication of twenty books on all phases of public health, known as the National Health Series. The development of state health councils, patterned after the national council, is also undertaken.

All progressive modern sanitarians realize that the many special phases of the science of public health are all closely interrelated. The National Health Council serves to coordinate the activities of the most important agencies of the country, and so to correlate their efforts that duplication is avoided and efficiency promoted. That in the end means the betterment of public health work in the United States.

Conclusions of the Committee for the Study of Nursing Education

(Appointed by the Rockefeller Foundation, June, 1919)[4]

Conclusion 1. That, since constructive health work and health teaching in families is best done by persons:

[4] The members of this committee were: Professor C.-E. A. Winslow, Chairman; Miss Mary Beard, Dr. H. M. Biggs, Miss Anne W. Goodrich, Miss M. A. Nutting, Miss Lillian D. Wald, Dr. William H. Welch, Dr. Livingston Farrand, Dr. L. Emmett Holt, Miss Julia C. Lathrop, Mrs. John Lowman, Dr. David L. Edsall, Dr. E. G. Stillman, Miss S. Lillian

(*a*) Capable of giving general health instruction, as distinguished from instruction in any one specialty; and

(*b*) Capable of rendering bedside care at need; the agent responsible for such constructive health work and health teaching in families should have completed the nurses' training. There will, of course, be need for the employment, in addition to the public health nurse, of other types of experts such as nutrition workers, social workers, occupational therapists, and the like.

That, as soon as may be practicable, all agencies, public or private, employing public health nurses, should require as a prerequisite for employment the basic hospital training, followed by a postgraduate course, including both class work and field work, in public health nursing.

Conclusion 2. That the career open to young women of high capacity, in public health nursing or in hospital supervision and nursing education, is one of the most attractive fields now open, in its promise of professional success and of rewarding public service; and that every effort should be made to attract such women into this field.

Conclusion 3. That for the care of persons suffering from serious and acute disease the safety of the patient, and the responsibility of the medical and nursing professions, demand the maintenance of the standards of educational attainment now generally accepted by the best sentiment of both professions, and embodied in the legislation of the more progressive states; and that any attempt to lower these standards would be fraught with real danger to the public.

Conclusion 4. That steps should be taken through state legislation for the definition and licensure of a subsidiary grade of nursing service, and subsidiary type of worker to serve under practising physicians in the care of mild and chronic illness and convalescence, and possibly to assist under the direction of the trained nurse in certain phases of hospital and visiting nursing.

Conclusion 5. That, while training schools for nurses have

Clayton, Dr. Lewis A. Connor, Dr. C. G. Parnall, Dr. Thomas W. Salmon, Dr. Winford H. Smith, Miss Helen Wood. The survey was conducted by Miss Josephine Goldmark, secretary of the Committee. The complete report is published in book form under the name of Nursing and Nursing Education in the United States.

made remarkable progress, and while the best schools of today in many respects reach a high level of educational attainment, the average hospital training school is not organized on such a basis as to conform to the standards accepted in other educational fields; that the instruction in such schools is frequently casual and uncorrelated; that the educational needs and the health and strength of students are frequently sacrificed to practical hospital exigencies; that such shortcomings are primarily due to the lack of independent endowments for nursing education; that existing educational facilities are on the whole, in the majority of schools, inadequate for the preparation of the high grade of nurses required for the care of serious illness, and for service in the fields of public health nursing and nursing education; and that one of the chief reasons for the lack of sufficient recruits, of a high type, to meet such needs lies precisely in the fact that the average hospital training school does not offer a sufficiently attractive avenue of entrance to this field.

Conclusion 6. That, with the necessary financial support and under a separate board or training school committee, organized primarily for educational purposes, it is possible, with completion of a high school course or its equivalent as a prerequisite, to reduce the fundamental period of hospital training to 28 months, and at the same time, by eliminating unessential, non-educational routine, and adopting the principles laid down in Miss Goldmark's report, to organize the course along intensive and coordinated lines with such modifications as may be necessary for practical application; and that courses of this standard would be reasonably certain to attract students of high quality in increasing numbers.

Conclusion 7. Superintendents, supervisors, instructors, and public health nurses should in all cases receive special additional training beyond the basic nursing course.

Conclusion 8. That the development and strengthening of University Schools of Nursing of a high grade for the training of leaders is of fundamental importance in the furtherance of nursing education.

Conclusion 9. That when the licensure of a subsidiary grade of nursing service is provided for, the establishment of training courses in preparation for such service is highly desirable; that

such courses should be conducted in special hospitals, in small unaffiliated general hospitals, or in separate sections of hospitals where nurses are also trained; and that the course should be of 8 or 9 months' duration; provided the standards of such schools be approved by the same educational board which governs nursing training schools.

Conclusion 10. That the development of nursing service adequate for the care of the sick and for the conduct of the modern public health campaign, demands as an absolute prerequisite the securing of funds for the endowment of nursing education of all types; and that it is of primary importance, in this connection, to provide reasonably generous endowment for university schools of nursing.

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